

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

Older women's experiences of menopause:
A feminist descriptive study of older women's knowledge
and attitudes toward menopause

Teresa Gracez

A thesis presented in partial fulfillment of the requirements
for the degree of Master of Arts in Nursing

Massey University
Auckland, New Zealand

September 2003

Abstract

As a result of improved health breakthroughs, most women can expect to live into their ninth decade. Consequently they will experience several stages of growth and development through which most women from previous centuries never had the opportunity to pass. Maturation changes often bring satisfaction, but the physical and social changes that accompany ageing may encourage some women to seek support and information from nurses. Although women today have more awareness of menopause and access to information and resource than women 30 years ago, it remains difficult for women to understand menopause in a non-contaminated manner.

This study brings together the two divergent perspectives on menopause: feminist and biomedical discourses. Feminist discourses most commonly regard menopause as a normal life transition whilst, biomedical models construct menopause as an illness requiring medical treatment. This qualitative descriptive study underpinned by feminist epistemology explores older women's experiences of menopause before menopause came to be perceived to be a problem requiring medical treatment. Semi-structured interviews were conducted with ten women, aged 70 years and over. Qualitative content analysis in this study resulted in two categories and eight themes of older women's experiences of menopause.

The findings in this study indicate that older women perceived menopause to be a 'natural' and 'normal' life developmental stage. Although the women viewed menopause to be a 'normal' passage in life and something that did not require much attention or medical intervention, the majority of women were quick to recommend that today's woman should seek help from menopausal symptoms from medical practitioners. This surprising variation of menopause being accepted as an illness for today's woman but not an illness 30 years ago suggests that the women's thinking has evolved in keeping with the social context they now occupy.

Acknowledgements

To my husband Fabio, thank you for your patience, for the missed evenings, nights, and weekends; for my distraction, and for your unwavering support. I know that you thought that there would never be an end, but here it is.

To my three sons who at times, had to endure their father's cooking and their mother's pre-occupation and absent-mindedness, thank you.

To my supervisor Professor Jenny Carryer, thank you for the confidence and support you have given me, especially in those dark moments during my personal crisis. Had it not been for you, I would have given up long ago.

Thank you to my friends and colleagues for their encouragement. At times, it seemed that you had more faith in my ability than I had.

To the ten women who gave me their valuable time and interest in sharing their experiences of menopause, thank you. I hope I have given voice to your stories to the best of my ability. Although all of you said that you have nothing to say, without your input, women today would not have the benefit of your experiences.

Finally, this study is dedicated to my mother, whose experiences of menopause I will never have knowledge of; and to my father, who during the course of this thesis courageously battled an illness and lost.

Table of contents

Abstract	i
Acknowledgements	ii
Table of contents	iii
Chapter One: Introduction and overview	1
1.1. Introduction	1
1.2. Significance of the study	2
1.3. Background to the study	4
1.3.1. The feminist paradigm	5
1.3.2. The biomedical paradigm	6
1.4. Personal interest and motivation	8
1.5. Justification	10
1.6. Aim of the study	11
1.7. Overview of the thesis	11
Chapter Two: Literature review	13
2.1. Introduction	13
2.2. Historical context	14
2.3. Feminist discourse	17
2.4. Sociocultural discourse	20
2.4.1. Menopause and myth	20
2.5. Psychosocial discourse	22
2.5.1. Menopause and age	25
2.6. Summary of feminist, sociocultural and psychosocial discourses	27
2.7. Biomedical discourse	28
2.8. Conclusions	33
Chapter Three: Research methodology	34
3.1. Feminist research	34
3.2. Method	37
3.2.1. Participant selection	38
3.2.2. Ethical considerations	39
3.2.3. Data collection	40
3.2.4. Rigour	42
3.3. Data analysis	44
3.4. Summary	46
Chapter Four: Achieving-recognizing menopause	48
4.1. Introduction	48
4.2. Meaning	49
4.3. Knowing-confirming	52
4.4. Worry-anxiety	56
4.5. Relief-release	58
4.6. Summary	60
Chapter Five: Connecting-engaging with menopause	62
5.1. Adaptation-adjustment	62

5.2. Support-counsel	66
5.3. Illness-malaise	72
5.4. Options-power to choose	76
5.5. Summary	80
Chapter Six: Discussion and conclusions	81
6.1. Review of the aim of this research	81
6.2. Findings	81
6.2.1. Theme One: Achieving-recognizing menopause	82
6.2.2. Theme Two: Connecting-engaging with menopause	85
6.3. Relevance to nursing knowledge	89
6.4. Limitations of the research	91
6.5. Concluding statement	92
Appendix A	94
Advertisement / Flyer	
Appendix B	95
Information sheet	
Appendix C	97
Consent form	
Appendix D	98
List of prompt questions	
Appendix E	99
Confidentiality agreement	
References	100

CHAPTER ONE: Introduction and overview

This thesis explores ten older women's narratives of their experiences of menopause. It is a feminist descriptive study in which women, aged 70 years and over share their experience of menopause prior to the current high level of medical and pharmaceutical interest.

1.1. Introduction

Menopause in strict definition is derived from the Greek word 'meno' meaning month and the Greek word 'pausis' meaning halt. Menopause, or the climacteric, is the intermediary phase between reproductive and non-reproductive ability. Climacteric derives from a Greek word meaning 'rung of the ladder'. It refers to a stage in a woman's life when fertility is decreasing and the menstrual cycle becomes irregular and eventually stops. Another popular term, the 'change' or 'change of life' is a vernacular term referring to the climacteric. As well, the 'change' is a term from an era when women's roles were defined by their reproductive capacity (Coney, 1994). The climacteric is a transitional phase during which ovarian function and hormone production are declining. This phase spans the years from the onset of premenopausal ovarian decline to the postmenopausal time when physical signs stop. Menopause refers only to the last menstrual period and can be dated with certainty after a woman ceases to menstruate for at least 12 consecutive months, on average around the age of 50. In simple terms, menopause is a normal physiological event where a woman ceases to menstruate. For the purpose of this study, menopause will be defined as a normal physiological passage from a reproductive to a post-reproductive stage in a woman's life when cyclical menstrual bleeding ceases.

The World Health Organization (1996) recognizes menopause as "... the time of a woman's life when reproductive capacity ceases ..." (p.1). WHO concluded that menopause occurs between 45 and 55 years of age, includes a variety of physiological signs, and that women spend a significant part of their lives in a postmenopausal state.

According to WHO (1996), in 1990 there were approximately 467 million women in the world, aged 50 years and over. Population projections indicate that this number is expected to increase to 1200 million by the year 2030. WHO has recommended that national health authorities examine the implications of the proposed rapid growth of postmenopausal women and anticipate the relevant health services, education, and promotional activities necessary to cope with women's health needs. In addition, they suggest research methods should be adopted to reflect the multifaceted nature of menopause including studies to determine how women perceive menopause.

1.2. Significance of the study

Scientific and technological advancements have prolonged life expectancy for women and men. The life expectancy of a New Zealand non-Maori female born in 1901 was 60.6 years. A New Zealand non-Maori woman born in 1996 is expected to live 80.2 years (Statistics New Zealand, 2000). As a result, most women can expect to live into their ninth decade. Consequently they will experience several stages of growth and development through which most women from previous centuries never had the opportunity to pass. According to the 2000 New Zealand census, half of all women in New Zealand will be aged over 40 by the year 2026. The shift in age structure reflects the decline in fertility since 1960 and the ageing of the baby boomer generation. The rapid growth in the number of elderly women is projected to increase after 2006 when the baby boom generation turns 65. With the growth rate averaging 1.9 percent per annum, the number of women aged 65 and over is expected to double between 1989 and 2026. By 2026, one in five women in New Zealand will be aged 65 and over compared to one in eight in 1989.

Over the next 10 to 15 years in New Zealand, more women than ever before will be entering into menopause. According to Sievert (2001), the recent increased interest and focus on menopause has been due in part to women living longer and as a consequence spending one-third of their lives postmenopausal. Because of the growing number of

women entering menopause, there has been increased demand for information about menopause.

There is a long list of symptoms which women, the popular press and general practitioners associate with menopause, such as hot flushes, headaches, insomnia, mood fluctuations, and so on (Kearns, 2002; Ogilvie, 2001; Sheehy, 1998; Utian, 1980; Warga, 1999). Although men have sometimes reported similar symptoms, there is little consensus that these symptoms may be tied to hormonal changes that are common to most men (Browne & Comer-Calder, 2002; Carruthers, 2001; Gould & Petty, 2000). The most widely recognized reason for prescribing Hormone Replacement Therapy (HRT) for menopausal woman is for control of menopausal symptoms and to replace hormonal loss (Anderson, 1998; Beasley, 1999; Colville, 2002; Cutson & Meuleuman, 2000; Kearns, 2002; Lewin, Sinclair & Bond, 2003; New Zealand Guidelines Group, 2001). This growing demand for HRT is based on the passage of 'baby boomer' women into menopause.

There is a vast mythology regarding the changes, many of them negative, which occur at the time of menopause. It is interesting to note the lack of information available to distinguish symptoms resulting from hormonal changes in women from those due to more general ageing in women and men. Recent reports on the abrupt end of a major study on women and long term use of HRT has caused concerns and some panic among many women regarding the risks involved in HRT use (Colville, 2002; De Boni, 2002; Hill, 2002; Rymer, Wilson, & Ballard, 2003; Shumaker, Legault, Rapp, Leon, Wallace, Ockene, Hendrix, Jones, Assaf, Jackson, Kotcher, Wassertheil-Smoller, & Wactawski-Wende, 2003). According to the reports, women who are taking HRT are put at a greater risk for heart disease, stroke, breast cancer and Alzheimers. These reports conflict with the information women have been given previously regarding the safety and security of HRT use. Contradictory information such as this leaves women no easy solution in making informed choices about HRT.

Though women today have more awareness of menopause and access to information and resource than women thirty years ago, it remains difficult for women to understand

menopause in a non-contaminated manner. This study will examine older women's experience of the menopause before medicine embraced it as a deficiency disease. How did women 'do' menopause 20 to 30 years ago? Who did they turn to for information? What happened? What did they know and how did they progress through it? What were their feeling, positive or negative, about menopause? Did they view menopause as a debilitating disease? This research will describe women's experience of menopause as it happened to them 20 to 30 years ago.

1.3. Background to the study

Menopause and related conditions are 'hot' topics – books, journal articles, studies, and the media reflect a who, what, why, and how of which product will bring the 'cure' to menopausal women. The modern woman lives in a society that values a quick fix, thus giving them relief and allowing them to continue with their busy and full lives without interruption. Scientific technology and research presents the possibility to liberate both women and men from irritating events, such as insomnia, obesity, depression, ageing, and hormonal symptoms. Despite the fact that women today are saturated with endless information about menopause, women are still left without clear answers or solutions (Budge, Stephens, & Carryer, 2000; Lemaire & Lenz, 1995; Turia, 1998).

In talking with elderly women, my interest is to gain a sense of the context in which menopause was experienced 25 to 30 years ago. In particular, I was interested in discovering if menopause was a highly significant event in their lives. As it has been, dominant perspectives of women's experiences of menopause have been largely determined by the biomedical interpretation of women's experiences of menopause, which have become so normal that we perceive it as such.

This study will bring together the two divergent perspectives on menopause: feminist and biomedical discourses. Feminist discourses most commonly regard menopause as a normal life transition representing freedom from reproductive burden. Biomedical discourses

describe hormonal loss at menopause as pathological requiring medical intervention to preserve the 'normal' woman.

1.3.1. The feminist paradigm

Western culture tends to put a high value on youth and the menopause is a clear reminder to women of their increasing age. For many women menopause may be a symbol of loss, for example, the loss of the ability to bear children. For women who have accepted childbearing and child rearing as their major role, menopause may symbolize an ending (Blackwell & Blackwell, 1997). Other women may see menopause as the first step to old age and associate it with the loss of attractiveness, of physical ability, and of energy (Whittaker, 1998). Some women view menopause with despair and sadness in relation to ageing (deBeauvoir, 1989). On the other hand, many women view menopause as a release and an opportunity for increased activities in their lives (Wright, 1998).

Any study on menopause cannot ignore the influence of social value, beliefs, and attitude on women's view of menopause. For women whose identity is based on nurturing and caring for a family or on sexual attractiveness, menopause is not a welcome sign. In Western society, one of the most obvious factors that operate in devaluing older women is the privileging of youth over age. Menopause is a clear reminder to women of increasing age. Stereotypical images of older women as doddering, feeble-minded, depressed, and wrinkled uphold the negative opinion of menopause (Beasley, 1999; Carlson, Li, & Holm, 1997)

In summary, the emphasis placed on women concerning their obligations and roles in society has created an onus on many women to conceptualize menopause in terms of a major loss. In addition, menopause has been confounded with ageing thus ensuring many women may view menopause as a symbolic event of great importance.

1.3.2. The biomedical paradigm

Whereas women in the past remained relatively silent regarding their menopausal experiences (Coney, 1994), today they are seeking information and support about menopause. Recent New Zealand literature indicates that women's main source of information about menopause is obtained from visiting their medical practitioners (Budge, Stephens, & Carryer, 2000; Turia, 1998). Where medicine had previously dismissed menopause as a state of mind in the middle age woman, they have altered their attitudes to menopause and regard it as a deficiency disorder requiring medical intervention (Beasley, 1999; Bell, 1990; Coney, 1994; Greer, 1991; Kaufert & Lock, 1997; Lock, 1982; Oddens, Boulet, Lehert, & Visser, 1992).

The construction of menopause as a disease has its roots in historical, political, and economic factors and is reinforced by scientific and medical discourses (Bell, 1990). The medical gaze has been extended to a new object of interest – the well woman at midlife. As Greer (1991) suggests, "...dealing with it requires no surgical or diagnostic skill." (p. 15) on the part of the medical practitioner and without medical treatment women have a choice to either lead a "...happy and effective life on one hand, or possible ignorance, misery, and discontent on the other." (Utian, 1980, p.1). Women requiring information on menopause or menopause-related conditions are compelled to rely on physicians, as gatekeepers for information on menopause. Menopause constructed as a deficiency disease creates a smokescreen that obscures the way many women view their bodies and their natural functions.

In addition to the medical profession, the pharmaceutical industry can be seen as having a vested interest in maintaining menopause as a disease state. According to Coney (1994), sales of HRT in Britain doubled over a two-year period to 10 million pounds. Hormone replacement therapy was promoted as the miracle cure for menopause related conditions. Claims that HRT is known to be highly effective for symptoms of hot flushes, vaginal dryness and mood fluctuations supported the conviction that HRT is a wonder drug and offers a 'cure' for menopause (Utian, 1980). In spite of no conclusive evidence, information

was presented and accepted as fact. There were claims that HRT was useful in osteoporosis (Burke, 2001; Gerrard, 2000) and is deemed to be falsely prophylactic, such as heart disease (Morelli & Naquin, 2002; New Zealand Guidelines Group, 2001; Seattle Midlife Women's Health Study, 2002). Thus not only do women supply the medical profession with a significant amount of income but also as Coney (1994) indicates, afford the pharmaceutical industry a steady source of revenue.

Estimates at that time, indicated that by the year 2000 one-quarter of menopausal British women using HRT would amount to 2 million women. Coney's (1994) research revealed that between 1981 and 1987 in Australia, the sale of oestrogen increased by 52 per cent and by 1987 there was one prescription per year for every 3.7 women ages 45 and over. Another study found that the number of women on HRT in New Zealand, has nearly doubled between 1991 and 1997 (Women's Health Watch, 2001). Interestingly, the study found decreasing number of women were using HRT for symptom relief, whilst an increased number of women were using HRT for presumed prevention of heart disease and osteoporosis.

The biomedical model defines menopause as a period of decline in a woman's life and as a deficiency disease. In this model, women need to be monitored, given prescriptions, and often surgical procedures to manage their health adequately. In this model, women are encouraged to see their bodies as dysfunctional and themselves as ill (Bell, 1990; Greer, 1991). Women taking HRT are advised to consult their medical practitioner for advice and are urged to have regular checks. This need for surveillance encourages repeat access to healthcare providers.

Coney (1994) argues that the use of HRT promotes a dependency on the medical industry and treats women as passive consumers. Further she argues, that the pharmaceutical companies and medical establishments have vested interests in menopause. This leads to the medicalisation of those aspects of women's health experience, which have potential for intervention regardless of the benefits or otherwise. Greer (1991) supports this view by arguing that medical innovations have not always been effective in serving women's

interest. She reasons that the old paradigm, in which the medical model is located, fragments and objectifies women's experience of menopause. This model places the emphasis on the disease process and pathology whilst, pathology has little to do with social systems or factors extrinsic to the woman. Greer (1991) argues that the locus of control and knowledge lies within the presumed expert – the doctor.

In summary, medical discourses have occupied and continue to occupy a central place in women's experiences of menopause. Thus, it now remains difficult for women to understand menopause in a manner that is not in effect colonized by medical thinking. A recent study in which over 80 New Zealand women at mid-life were asked about how they managed menopause, summarized current understanding (Budge, Stephens & Carryer, 2000). Universally the women expressed huge need for information, fear of doing it incorrectly, the sense they *should* take HRT even if nothing is wrong and the need to have a doctor confirm how they were doing.

1.4. Personal interest and motivation

My interest in this topic stems from my own experience of 'early' menopause in addition to two factors that influenced my choice of topic. First, when I consulted my doctor and told him that I believed I was in menopause, he dismissed my legitimate concerns by telling me I was too young and undertook to 'treat' my symptoms. At my insistence and to humour me, he ordered blood tests. Two days later he called me personally and in great excitement, to inform me that I was not menopausal, but post-menopausal and urged me to visit him for tests and a prescription for hormone replacement therapy. Although I did not initially consult him because I was unwell, he had now determined that I was 'sick' and therefore according to him, in need of medical management. My reaction to his patronizing attitude of 'what do you know about your body', and the belittling of my knowledge alerted me to the fact of how powerless I was, and that I apparently needed him as the gatekeeper to confirm what I knew already. How many women over the years have just accepted this 'expertise' and surrendered their bodies?

The second factor was the reaction of my friends and peers. They were astonished to hear that I was menopausal; this happens to old women and I was far too young. Was I certain? Did a doctor tell me? I was warned that my normal life as I know it, will now be over. I had to be prepared to suffer ghastly menopausal symptoms such as hot flushes, extreme changes to my skin, and slowly begin my decline into old age. My husband would become a martyr, as he would have to suffer through these changes in addition to my erratic mood swings. As a nurse, I was alarmed by the advice given to me by other nurses as I became conscious that their knowledge was both medically embedded and based on myths. I speculated what if I had not told them, would they know? How would they know? Why did I tell them? How can I be 'old' at 37 years of age? Should I have not exposed my condition? Should I have remained invisible? Menopause is permeated with negative symbolism and this invisibility according to Greer (1991) is based on the fact that menopause implies negative elements concerning women and identity. This research allows women to examine the central role social historical practices play in shaping and producing women's lives and roles.

These incidents stimulated my interest in menopause and in particular other women's experiences of menopause. After much reading and searching I found there was a paucity of information both in the popular and academic literature providing any realistic information. On questioning my colleagues and other women nearing the age of menopause, I found even more confusion, myths and old wives tales. Colleagues recited to me what the 'experts' declare about menopause. I discovered there was limited New Zealand material and the opinions offered were either from Great Britain or North America. When I researched the literature, I discovered that the voices of menopausal women of 20 to 30 years ago were silent.

I undertook this study for two reasons. First, as a woman, I believe women's experiences need to be valued and documented. This research will provide the means of capturing some women's experiences of their reality of menopause. Second, from a nursing perspective, this topic provides an opportunity to understand a human experience outside the context of medicine and a basis for the uncritical uptake of medical 'talk' nurses do without considering its 'fit' with a nursing ethos.

1.5. Justification

A search of New Zealand literature on menopause revealed limited material on older women's experiences of menopause. Turia's (1998) and Anderson's (1998) research on menopause did cite some women's memories of their mother's menopause though, the data was limiting as it centred on the women's *perceptions* of their mothers' experiences. Beasley's (1999) thesis included four narratives from women, aged 70 years and over that portrayed menopause as an enduring and taboo subject matter.

This thesis will expand on the current research to include ten older women's experiences of menopause. Why focus on older women's experiences of menopause in this study? What could these women possibly have to offer today's woman? Women who experienced the 'change' 20 to 30 years ago did not talk openly about their health and especially not about menopause. Important matters such as this remained unspoken, because they were either private or unimportant (Robertson, 1995). The women in this study were part of a generation raised with traditional gender role expectations. Most were encouraged to stay home and raise children (Fodor & Franks, 1990). However, as Greer (1991) conveys, in some societies, older women are recognized for their knowledge of how things are. They are the prime educators of children – clearly an important role. What recognition does the Western world offer older women and their knowledge? What value does Western society place on older women's knowledge and experience? Are women's experiences of menopause dependent on society's perception on how a woman should act or behave? What effect if any, would women's shared experiences of menopause have on women's knowledge of menopause? Will this knowledge impact or give individual power over a woman's life?

This study will give voice to older women and a means to express their reflections so that perhaps other women may no longer have "...to rely on higher status, powerful authorities in the public domain for knowledge and truth." (Belenky, Clinchy, Golberger, & Tarule, 1997, p. 60).

1.6. Aim of the study

With the above in mind, this thesis aims to capture, retrospectively, the experience of menopause prior to it becoming an area of medical interest. This qualitative descriptive study underpinned by feminist epistemology will examine older women's experiences of menopause before menopause became to be perceived to be a problem requiring medical treatment. The specific research question is: What experiences of menopause did women have 25 to 30 years ago?

1.7. Overview of the thesis

Chapter 1, this chapter, introduces the study and describes the background and purpose of the study. The definition of menopause is briefly explored and is defined in this study as a normal physiological passage in a woman's life. This chapter has included the introduction of the feminist and biomedical models that have influenced women's experiences or perception of menopause.

Chapter 2 provides a brief overview of the literature on menopause relevant to this study. This chapter will include a synopsis of the literature on the way in which menopause has increasingly become a topic of medical interest. The feminist and medical perspectives on menopause will be presented in four discursive themes: feminist, sociocultural, psychosocial, and biomedical.

Chapter 3 introduces the research methodology and method adopted in this research. I will discuss the grounds of using a qualitative study in order to gain a vivid insight and awareness of women's narratives within the context of their experiences. I will discuss how the feminist perspective was engaged throughout this study in capturing the views of women who passed through menopause before it became an event requiring medical attention or intervention.

Chapters 4 and 5 will present the description and analysis of the data collected in this study. Two themes will be explored in the context of available literature: achieving-recognizing menopause and connecting-engaging with menopause to form a descriptive picture of how women experienced menopause thirty years ago.

Chapter 6 provides a summary of the findings and examines the relevance these findings have for women and for nursing. There is also discussion on the limitations of this study and possibilities for future research.

CHAPTER TWO: Literature Review

This chapter will provide an overview of the literature that relates to menopause and its medicalisation. While literature related to older women's experience of menopause is virtually non-existent, a review of the relevant literature about menopause is appropriate to this thesis, as it reflects the views that have shaped women's understanding of menopause.

This chapter will focus on appropriate literature arranging it into four discourses: feminist, sociocultural, psychosocial, and biomedical. Each discourse projects an image of a stereotypical menopausal woman as 'normal' that some women may measure themselves against. I will argue that women can no longer place themselves outside one or more of these discursive locations, therefore I am interested to present women's experiences before the discursive field of menopause became so heavily invested by medicine.

2.1. Introduction

Recent literature on menopause has focused on the meaning of menopause (Anderson 1998), the significant problems during menopause (Defey, Storch, Cardozo, Diaz, & Fernandez, 1996), perimenopausal women's responses to the process of menopause (Quinn, 1991), women's decision-making on hormone replacement therapy (Budge, Stephens, & Carryer, 2000; Turia, 1998), and women's roles, attitudes, and expectations about menopause (Beasley, 1999; Hunter, O'Dea, & Britten, 1997)

The essence of Sandra Coney's (1994) book on menopause, focused on the way the medical industry changed menopause from a natural life transition into a disease requiring treatment. Her excellent analysis described medicine's interest in menopause and she offers women comprehensive information about menopause. Coney explored the role middle-class Caucasian well women in midlife have played in the politics of medicine and menopause. Whilst Coney's research produced an impressive collection of information on

menopause, an important aspect of women's experience of menopause remained largely unrecorded and unrecognized – women's experience of menopause before it became to be perceived as a problem requiring medical intervention.

The situation of women and medicine has a long history and in order to appreciate the connection between women, menopause and medicine, I will include an examination of some of the literature binding this close relationship.

2.2. Historical context

From the time of ancient Greece through to the 18th Century women and men's bodies were thought to be similar (Jones, 1994; Lupton, 1994). It was believed that women's internal organs were structurally analogous to men's external genitalia. The difference between the sexes were not necessarily structural, but rather a matter of temperatures. In a historical essay of reproductive theories, Tuana (1988) describes how the principle of women's biological inferiority was created and developed on the basis of scientific assessment of women and nature founded by Aristotle. Tuana (1988) proposes that although Aristotle correctly deduced that reproduction begins at puberty and ends in old age, his assumptions were erroneously based on the physiological differences between women and men, with particular emphasis on menses (female semen) and male semen.

Female semen is abundant and resembles blood. Male semen is scarce and is quite unlike blood. Aristotle claims that these differences are accounted for by the fact that women are unable to 'cook' their semen to the point of purity-thus 'proof' of their relative coldness. (p.148-9)

According to Aristotle, men were believed to produce more heat than women, and women were cold and weak as a result of their biology; he concluded from this that men were superior beings. This perception of women as cold in nature Tuana (1988) notes was supported further by Galen's biological explanation of women's inferiority by using creative illustrations of a woman's anatomy as the cause of women's coldness and inferiority. Tuana (1988) argues that the Aristotlian thesis of women's biological inferiority

and Galen's explanation of the cause of this inferiority persisted well into the 16 century and cemented women's relationship with nature.

By the 18th century the idea that social order should be based on the natural order began to gain credibility and women's biological structure was finally differentiated from that of men (Formanek, 1988; Jordanova, 1989). In the new social order, women's identity was constructed within their reproductive role with "...emphasis on and idealization of motherhood and feminine qualities..." (Formanek, 1988, p. 203). The ideal woman was considered to be a faithful, submissive, and competent wife and a dedicated and loving mother, the "... intrinsic quality of the Eternal Feminine..." (deBeauvoir, 1989, p. 254). This model of the virtuous woman and female goodness defined women's place and her behaviour in it. This ideal image of a feminine woman was held up as a paradigm by which all women were judged and (as Greer (1999) argues), women continue to be judged today. Since menopause was viewed as the end of women's reproductive capacity, it was seen as the end of women's usefulness. Fertility and femininity became inseparable.

In the 19th Century, medicine subscribed to the belief that a woman's uterus and ovaries controlled her body and behaviour from puberty to menopause (Ehrenreich & English, 1979). Menstruation was viewed as a pathological problem; pregnancy rendered women invisible on the grounds that pregnancy was a disease; and finally, menopause was the "... death of the woman in a woman" (Ehrenreich & English, 1979, p.11) rendering woman purposeless during and after menopause. These myths were maintained by 'male' physicians, who as 'highly qualified experts' in power positions supported by church and state, kept women submissive and obedient to doctor's orders (Ehrenreich & English, 1979). Thus menopause was divided into two discourses as Formanek (1988) explains:

Men tended to view 'the changes' as the beginning of a decline of physical, emotional, and cognitive functioning. For most women, however, it was a golden age, a time at which pregnancies were no longer dreaded. (p. 204)

The 20th century brought new discoveries in the area of health and women's average age life expectancy surpassed age 75. Menopause was relatively ignored by medicine until the 1960s when medicine altered its attitude and viewed menopause as a disease process

(Coney, 1994; Wilson, 1966). In the 1960's conjugated oestrogen was presented as the elixir of youth and the panacea to cure all ills (Klein & Dumble, 1994; Wilson, 1966). The doses of oestrogen replacement (ERT) prescribed to women were excessive and prolonged, resulting in six times the incident of uterine cancer (Coney, 1994; Klein & Dumble, 1994). As ERT use decreased, the incidence of endometrial carcinoma decreased (Klein & Dumble, 1994). The 1980's brought more research on ERT along with the addition of synthetic progestogen and a new name, hormone replacement therapy (HRT). Once again medicine assured women that with the correct dose and under medical supervision, women could be confident that HRT was very safe (Klein & Dumble, 1994; Utian, 1980).

Recently, the number of women on HRT in New Zealand doubled from 12 percent in 1991 to 20 percent in 2000 (North & Sharples, 2001). The major reason given by women for HRT use was, relief from symptoms or preservation of femininity (Fauconnier, Ringa, Delanoe, Falissard, & Breart, 2000; Lewin, Sinclair, & Bond, 2003). Recent research on the risks and benefits of long term HRT use has raised considerable concern about the risks of HRT (New Zealand Guidelines Group, 2001; White, 2002; Women's Health Watch, 2001).

Feminist discourse offers a number of perspectives on the process of menopause, however I will focus on four paradigms that are particularly relevant to this study. First, I will present the feminist view of menopause as a positive life event or transition in a woman's life (Barile, 1997; Gannon & Ekstrom, 1993; Greer, 1991; Phillips & Rakusen, 1996). Second, I will explore the sociocultural myths and attitudes that are responsible for some menopausal symptoms (Barile, 1997; Harding, 1996; Jones, 1994; Lock, 1982; MacPherson, 1981). Third, I will include discussion on some of the issues within a psychosocial paradigm, such as ageing that may influence women's experience of menopause (Ballinger, 1990; Defey, Storch, Cardizo, Diaz, & Fernandez, 1996; Roberts, Chambers, Blake & Webber, 1992). Finally I will review some of the feminist literature that argues the medicalisation of menopause (Bell, 1987; Broom, 1995; Coney, 1994; Greer, 1991; Oddens, Boulet, Lehert, & Visser, 1992).

2.3. Feminist discourse

The feminist argument presents menopause as a process that is a natural, physiological and a non-pathological event that requires no medical treatment. Some women view menopause as a normal and natural process, similar to puberty, in that it can be both a wonderful or terrible life change. Robertson (1995) narrates her personal experience of her passage into menopause. She recites what influence her mother's whispered tales of the 'change' had on her own experience of menopause, particularly tales of her grandmother, who was driven 'mad' with suicide as her salvation. The author explains her reasons for her predetermined decision to take HRT in order to be ready for when her 'time' would come. In spite of this, she experienced great insomnia and fatigue, which hurled her into a deep depression with thoughts of death as her only relief. Suddenly, she recognized what she was experiencing was more than likely the same feelings as her grandmother "...who lost her mind at the change, going into a depression that refused to lift." (p.103). The essence of this narrative is the author's recognition that what she was experiencing was, 'normal' menopausal symptoms.

In contrast to Robertson's experience, many women discover a sense of liberation (Asso, 1983; Greer, 1991), a second adulthood (Sheehy, 1998), a new beginning (Wright, 1998), and have nothing to fear (Forster, 1994) and as a consequence allow themselves to age naturally and gracefully (Beasley, 1999).

For some women, menopause is not a loss or a symbol of losses, but a relief from the burdens of birth control and pregnancy. More than one woman has written about the freedom of no longer having to worry about her fertility, as well as the increased feelings of independence menopause brings along with other positive aspects of menopause (Forster, 1994).

In a qualitative study of 15 women, aged 48 to 62 who experienced a 'natural' menopause, George (2002) found that most women had positive responses to menopause. The majority of women in the study expressed relief from the burden of birth control and menstruation

and recognized menopause as a transition from one life stage to another. Few of the women had any memories of their mother's experiences of menopause except for one woman who "... remembered her mother going through menopause but that her mother did not make an issue of it." (p. 82). One of the implications from this study was acknowledging each woman's perspective of menopause as the norm.

In another study involving 2500 mid-life women, Siegel and Doress-Worters (1994) found that the majority of women expressed feelings of relief about menopause. The women believed menopause signaled a life passage when worries of unwanted pregnancy gave them an independence and freedom they never experienced before. Although many women in this study described how some symptoms of menopause made them uncomfortable, they took these symptoms in stride and did not let it disrupt their lives. Menopause was seen as a mid-life marker for women and a reminder to take time to assess their own health to prepare their body and mind for the next phase of their life.

A similar study by Berger and Forster (2001) investigated the physical, psychological and sociocultural menopausal experiences of 70 women, aged 45 to 70. The majority of the women described menopause as a 'normal' process and verbalized the difference between their expectations and their actual experiences. The women anticipated symptoms based on what they read or heard however, they were surprised at their own experiences of minor symptoms. All the women collectively described menopause as a non-event and a normal process in their life.

Gannon and Ekstrom's (1993) research on attitudes toward menopause involved 581 women and men, aged 18 to 85, and measured their responses on three categories: medical problems, life transition, and ageing. The results of this study indicated how medical problems extracted significantly more negative and fewer positive attitudes than the other categories of transition and ageing. Interestingly, the study found the older the individual, the less negative attitudes that were held by both women and men. The tendency to focus on the positive aspects of menopause, such as adult freedom and beginnings of a new life stage was voiced by both women and men.

The general view by a majority of women in a descriptive study by Hunter, O'Dea and Britten (1997) of 45 women aged 49 to 51, was a preference for a 'natural' menopause. The women were questioned on the advantages and disadvantages of HRT. Three themes emerged from the findings: HRT can be taken for severe symptoms; doctor – patient relationship was contingent on the assertiveness of the woman; and women reflected on "... whether it was 'natural' to take medication for menopause." (p. 1545) .In addition, women questioned the long term effects of HRT use and welcomed alternate treatment strategies for menopausal symptoms.

MacPherson (1981) presents a persuasive argument that menopause is viewed by women as a normal and natural event that occurs in all women. Further she contends, menopause is not an issue for women – the serious issue is the risks and benefits of treating healthy women going through a normal event in their lives.

According to some feminist scholars, menopause is a natural physiological event in a woman's life, and the symptoms of menopause vary widely in degree and duration, from extremely evident and bothersome to barely noticeable. Each woman's experience of menopause is subjectively determined by nutritional, psychological, economic and sociological factors, which are related to the degree of a woman's psychosocial situation and societal attitudes at the time of each woman's experience of menopause (Fiske, 1993).

In summary, some feminists point out how the physiological changes that mark the end of a woman's reproductive cycle are steady, long lasting and difficult to measure in the majority of women. It is misleading to suggest normal women will experience better health by taking medication. Asso (1983) highlights how menopause has "... become the scapegoat for previously existing problems ..." (p. 125) as it coincides with a time in women's lives when many other changes are often taking place. Even though the majority of the women view menopause as a normal life transition, the medical discourses on menopause continues to construct and situate the 'normal' for women's lives.

2.4. Sociocultural discourse

Although physiological issues dominate much of the literature over the last 25 years on menopause, some feminist scholars have given more attention to the social and cultural factors, which may influence women's experiences of menopause (Berger & Forster, 2001; Harding, 1996). Although hormonal and physiological changes may create some difficulties during menopause, the characteristics and experiences may be related less to the actual biological changes and more to sociocultural events (Jones, 1994).

For hundreds of years, social values have been constructed and internalized based on a masculine perspective that attributes specific roles to women (Ehrenreich & English, 1979; Fisher, 1986). Women's sociocultural milieu and lifestyle reflect their values, beliefs, commitment, attitudes and patterns of functioning during life events. A woman is deeply immersed in relationships with other persons, to a culture and to society. These factors Spitzer (1995) argues, influence a woman's ability to maintain health and well being.

deBeauvoir (1989) draws a highly complex map of women and their position in the world. She contends that women's situation is particularly perplexing since women struggle between their status as free and autonomous human beings with the fact that they have been socialized into a world where men see them as 'Other'.

2.4.1. Menopause and myth

Feminist research in the 1980s began to dispute the common myth that all changes in mid-life are caused by menopause (Asso, 1983; Greer, 1991; Lee, 1998; MacPherson, 1981; Matthews, 1992). Myths introduce a semblance of understanding and order in the world and exist along science to explain behaviour, which develop into beliefs and ways of knowing (Formanek, 1988; Lock, 1982). The very embodiment of myth is how it transforms history into nature (Formanek, 1988; Kaufert, 1982). What myths bestow is a

natural image of reality. Myths do not deny phenomenon – its purpose is to speak about phenomenon, thus giving it a natural and eternal existence (Lock, 1982).

According to Lee (1998), discourses on menopause are grounded on four myths, which mask the inequities of women's position in health: the 'raging hormone' myth; the 'motherhood' myth; the 'angel in the house' myth and 'woman as an object' myth. Each myth perpetuates the ways in which myths and stereotypes strengthen women's appropriate or 'natural' behaviour as part of their health and well-being.

Academic historians such as Smith-Rosenberg (1985) and Jordanova (1989), emphasize the value in understanding women's social history in order to come to terms with the reality of women's world today. Smith-Rosenberg's (1985) work on gender-role socialization reveals the influence economic, demographic and social position explain an individual's rights, power and personalities. In the 19th century, male physicians depicted women as fragile creatures subjugated by their reproductive processes. These views reinforced a conservative view of women's social and domestic role, "... genitals determined gender, gender determined social role ..." (Smith-Rosenberg, 1985, p. 23).

Similar research on gender in the 18th and 19th centuries by Jordanova (1989), supports this:

Over the last twenty years or so historians have become aware of the need to unpack the processes through which 'naturalization' takes place, whereby ideas, theories, experiences, languages, and so on, take on the quality of being 'natural', permitting the veiling of their customary, conventional and social characteristics. Understanding such naturalization is integral to the project of delineating and explaining the precise nature of scientific and medical power. (p. 5)

Whilst feminist arguments that menopause as a normal and natural event presents a convincing perspective, they continue to struggle to find the balance between the obvious physiological influence on women's bodies and the sociocultural factors that interact with them. As Kaufert and Gilbert (1986) point out, women's experiences of menopause as natural and uneventful is the epitome of privilege where middle-class Caucasian women with access to healthcare and disposable income, are able to devote time and money in treating menopausal symptoms with diet, exercise, and herbal remedies. Indeed, Spitzer

(1995) found women's experience of menopause is related to social situation, economic development and class difference. There is no consideration given to poor women who have no access to healthcare or little time to spend on themselves. It continues that delivery of healthcare is innately connected to the political, economic, and social struggles of women's lives.

According to MacPherson (1981), medicine's reaction to menopause is "...grounded in political reality." (p 96) and is another example of the misogynous attitude toward mid-life women. She points out that mythology has historically been used alongside science to explain women's behaviour, which in turn developed into beliefs and truths. These 'truths' and mythical arguments have been used against women to romanticize the image of a woman and the ideal definition of femininity includes four virtues – "piety, purity, submissiveness, and domesticity." (p 99). As MacPherson (1981) explains:

These virtues were necessary to hold family together in an increasingly materialistic and mobile society. Woman's role was to guide the more worldly males past the double dangers of atheism and unfettered sexuality.
(p. 99)

For feminists, women's empowerment means control of women's own bodies. It can be argued that myths as constructs of the medical profession support their claim over women's bodies. Feminist discourses combat assumptions that women are not capable of understanding, choosing or acting in accordance with their own health needs. Women's awareness of their reproductive role, responsibilities and expectations from others play a significant part of their gender-role development (Gilligan, 1982). The relationship between women's health and illness is based on the social construct of illness and women's roles that are situationally determined. Negative images of mid-life and older women continue to pervade menopausal literature in its myths, expectations and norms.

2.5. Psychosocial discourse

During the twentieth century improved medical technology and public health have resulted in an average life span for women of 75 years. This means a woman has an average 25

years to live a happy and healthy life, beyond her menopause, in comparison to the meager 30 years of life the average woman living in 1000 A.D. (Lee, 1998). Longer life expectancies have challenged women with a number of situations never faced by the generations of our grandmothers and great-grandmothers. Longer life expectancies have also reshaped women's experiences of menopause by placing emphasis on the physical signs of ageing experienced by women during menopause (Browne, 1998; Greer, 1991).

In addition, some feminist scholars contend that biomedical discourses have clouded and confused women's understanding as to what happens to a woman as she ages with what happens to a woman experiencing menopause. Greer (1991) labels menopause as a normal and natural "...celebration of what could be regarded as the restoration of a woman to herself." (p 53) and argues that menopause has been infected by sexist and ageist attitudes that construct mid-life women as deficient. In addition, she maintains that women's reality of personal distress and social rejection has been denied, by assumptions that women's behaviour is primarily caused by hormonal changes.

Klein and Dumble (1994) claim that healthy mid-life women are disempowered by the emphasis on negative symptoms of menopause through various scare tactics such as inheriting disabling diseases such as osteoporosis, cardiac dysfunction, loss of sexual attractiveness, and becoming a "...burden on the state." (p 329). They argue that by frightening women into behaving in ways society deems to be appropriate takes away the women's experience of what is normal. It is no wonder as Lewis (1993) points out that some women see menopause with fear and suspicion. As Worcester and Whatley (1992) explain:

... many women still do not know enough about the normal healthy workings of their bodies to resist a mass manipulation of the fear factor.
(p 23)

The 1976 edition of the Boston Women's Health Book Collective, *Our bodies, ourselves*, downplayed the physical symptoms of menopause and placed emphasis on the importance of women's roles and relationships during menopause, adhering to a psychosocial model of menopause. Women were encouraged to accept menopause as a life transition resulting

from family responsibilities and/or empty nest syndrome and to reject the physical symptoms of menopause – just grin and bear it – it will pass. In an effort to distract women from the physical symptoms, it was suggested that women should join a club, do volunteer work, or discover new hobbies.

Twenty years later, the 1996 edition of the Boston Women's Health Book Collective (edited by Phillips and Rakusen), *'The new our bodies, ourselves'* devotes a fraction more information on the physical symptoms of menopause however it also includes some discussion on HRT. Nonetheless, the 1996 edition upholds the view that a successful menopause is not about the physical symptoms but is dependent on a woman's lifestyle and socioeconomic situation. Menopause, they maintain is a natural and normal process giving women the opportunity to grow and develop with "...a surge of new energy..." (p. 449) and continue to emphasize a self-help approach to menopause. They caution that mid-life women may be subjected to over-treatment of menopausal symptoms by the ever present dominant biomedical view of menopause as a deficiency disease as well as manipulating women's fears about menopause and ageing.

Women's psychosocial adjustment to menopause was the focus of a study by Roberts, Chambers, Blake and Webber (1992) with two comparable groups of women. Group A consisted of 35 women randomized to receive Calcium supplements, 18 women received HRT and Group B consisted of 37 women not taking HRT. Both groups of women were asked to complete a questionnaire that measured psychosocial adjustments the women during menopause. The results indicated that only 14 percent of women were not adjusting well to menopause citing concerns about health care issues, anxiety, anger and body image difficulties. Interestingly, there was no difference in change of psychosocial adjustment between the groups. The findings suggested that HRT was not always an effective treatment for menopausal symptoms and recommended access to counseling service should be a factor in assisting women with psychosocial issues during menopause.

2.5.1. Menopause and age

The emphasis that Western societies place on youth, especially among women is well documented, as Greer (1991) and Coney (1994) detail, and is grounded on the negative assumptions and stereotyping of older women. Although research illustrates menopause to be a natural process, many women believe that menopause ages women (Gullette, 1997). Negative perspectives on women and ageing may be seen as a symbol of older women's diminished value.

DeSouza (1994) supports these assumptions in her essay on women's narratives on menopause. She observed that the majority of women's attitudes on menopause were determined by the cultural differences in women's needs and expectations. For example, the author found the fear of aging in Western culture was a key development to a woman's social and cultural context. In contrast, a woman's experience of menopause in South Asia is linked to worth, privilege, respect and power status as a result of her age. In this situation, positive attitudes to menopause proved to be dependent on cultural beliefs, traditions and practices. In Western countries, the often fearful and negative attitudes of ageing are linked with menopause and overshadow women's personal and professional capabilities. These meanings are reinforced and reiterated daily through popular media (Whittaker, 1998; Wright, 1998).

In a qualitative study of 12 women, aged 40 to 60, Quinn (1991) found women's view of menopause as a normal and natural passage in a woman's life. However, the women expressed concern about negative attitudes by society toward older women. Whilst the women recognized menopause to be one sign of getting older, and "... a paradox of emotions forced the women to confront their own mortality." (p. 28). The majority of the women sorted out the necessary adjustments and changes they felt were needed in their lives to accommodate their physical and emotional changes.

Ageing is a universal, natural and inevitable process that happens to women and men. Menopause is a universal and definitive mark of ageing in a woman's life (Dickson, 1990).

Greer (1991) writes:

At menopause as never before, a woman comes face-to-face with her own mortality. A part of her is dying. The grief of menopause affects every woman consciously or otherwise. (p. 124)

Some women struggle with society's demonstration of the double standard on ageing that corroborates a person's worth and abilities, solely by age. Browne (1998) suggests what is essential for all women is:

... to draw more attention to women's view of aging in their own words, one the documents and celebrates their strengths and resistance to oppression.
(p. 155)

Phillips and Rakusen (1996) challenge the common myth that all the changes women experience at mid-life are caused by menopause. They argue that age and ageing is not simple for either women or men. The authors point out, that in comparison to older men, older women have more to contend with, as women are more likely to be poor and/or widowed, to be living alone, or to be institutionalized. Furthermore, men also experience mid-life changes that may include decreased sexual function, depression, the loss of muscle mass, and a sense of well-being, however these changes are more gradual in men than the mid-life changes experienced by women.

There is little doubt that there are some age-related concerns in cognitive functioning with advanced age for women and men. Ballinger (1990) emphasizes that problems that may arise during menopause may be better explained by life events and negative stereotypes associated with ageing for women rather than by hormone levels. For women who perceive menopause as a time of loss, depression can be inevitable and a natural phase of the grieving process. In fact, Ballinger (1990) stresses, depression may be a 'normal' reaction, given the sociocultural and psychosocial factors imposed on women in Western cultures, and a necessary stage in the process of adjustment.

In a study of 78 postmenopausal women and 45 gynecologists, Defey, Storch, Cardozo, Diaz and Fernandez (1996) found many contrasts between the conceptions gynecologists had concerning their patients. The gynecologists perceived women to be depressed, anxious and expected women to be worried about loss of fertility and growing old. Instead, the women stressed menopause as a life event giving them relief from burden of daily family activities and the opportunities to reflect on 'I want' instead of 'I must'.

Similar results were found by Stephens and Ross (2002) in their study of 494 women aged 45 to 60:

...those who are currently using HRT report no more or less positive affect, negative affect, or psychological distress than those who are not using HRT.
(p. 413)

More and more women enter menopause challenging the gender-role stereotype associated with age and welcome a world in which 50 or more years of gathered wisdom could guide their lives (Loppie & Keddy, 2002). Women who confront the myth of eternal youth accept menopause and ageing with independence, wisdom and a sense of awareness of becoming productive and as a consequence thrive in their status as middle-age adults growing older (Byles, 1998).

In sum, whether the emotional dilemmas of some women at menopause are the result of physiological changes or the result from the psychosocial issues imposed by society cannot be answered completely (Darke, 1996). Biomedical discourses on menopause focus on physiological symptoms painting a negative picture of menopause and ageing for women rather than describing menopause as a normal life event.

2.6. Summary of feminist, sociocultural and psychosocial discourses

Feminism is fundamentally a political movement concerned with women's oppression and the ways and means of empowering women (Tong, 1998). Feminist work on menopause has made a significant contribution to the understanding of the life events of mid-life

women. Feminists have had to struggle to find the balance between the importance of physiological menopausal symptoms on women's bodies and the sociocultural and psychosocial factors that interact with them.

Some feminists are critical that much of the biomedical research on menopause is based on the assumption menopause is a disease or the cause of disease. In contrast to biomedical research they maintain, feminist research has confirmed that in spite of pressure and negative attitudes from society, most women develop adaptive ways to deal with menopause (Hunter, O'Dea & Britten, 1997; Loppie & Keddy, 2002; Stephens, 2001). Further they argue, menopause is a natural process in a woman's life and its meaning has been distorted by society, religion, education, mythology, and medicine.

Menopause itself is not a dilemma for women, however the dilemma lies in the power imbalances of societal attitudes and perceptions of women and menopause. Women are beginning to challenge myths and stereotypes and discovering their bodies and taking responsibility for their health. Without knowing what the 'normal' is, how can a woman ascertain what the outcome of a particular therapy will do for her.

2.7. Biomedical discourse

The biomedical definition of menopause as a deficiency disease requiring medical intervention developed late in the 20th century (Lupton, 1994). The biomedical model promotes menopause as a universal female disease characterized as an endocrine deficiency disorder requiring HRT (Blackwell & Blackwell, 1997; Coney, 1994; Greer, 1991). The medical view acknowledges menopause as a stage in a woman's life when there is cessation of menses along with ovarian failure (Utian, 1980). The medicalised meaning of menopause came to be popular in the 1960s when a prominent American gynecologist, Robert Wilson (1966) advocated menopause as a hormonal defect in a women that threatened their 'feminine essence'. As the leading advocate of oestrogen replacement, Wilson suggested oestrogen would restore women to their 'normal' function and retard the

ageing process. This dramatic change from the 1940s when menopause was described as not involving any alteration in a woman's life (Posner, 1979) to the 1960s when menopause was defined as a loss in an ability to produce oestrogen, is what some feminists describe as the medicalisation of a woman's mid-life (Bell, 1987; Coney, 1994; Greer, 1991; Kaufert & Gilbert, 1986; Lock, 1998).

According to Conrad (1992) when a problem is defined as medical, it is removed from the public domain, where there can be discussion among ordinary people, and placed in a domain where only medical people can discuss it. Conrad (1992) explains:

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. (p. 211)

According to Lock (1998), medicalisation is the process whereby certain behaviours, problems and events are conceptualized and treated as a disease. Accordingly Reissman (1989) claims medicalisation as a process whereby certain processes are defined in terms of health and illness and medicine becomes the means for removing or controlling those experiences defined as 'abnormal'. As Greer (1991) writes:

The medicalization of menopause is the last phase in the process of turning all the elements of female personality that do not relate to the adult male into pathology. Doctors cannot change social, cultural, economic or political conditions; they can only try to tailor the patient to fit better into her circumstances. (p. 120-1)

In a biomedical model, menopause with a loss of ovarian oestrogen is regarded as a deficiency disease, treatable by replacing hormones, thus turning "... it from being a stage in the normal process of aging into a hazard to health..." (Kaufert & Gilbert, 1986, p. 9). Physicians also have the social obligation to "...restore the individual to normality." (Kaufert & Gilbert, 1986, p.11) consequently keeping women from becoming "... a burden on the health care system..." (Kaufert & Gilbert, 1986, p. 11). This notion suggests that since women are postmenopausal for 20 to 40 years, it follows that women are in a diseased state for a significant portion of their lives.

Another view by Lock (1998) stresses:

The category 'postmenopausal' is now applied to all women once past reproductive age who by definition are deemed to be at risk for heart disease, osteoporosis, and other diseases associated with aging. (p. 180)

This model has led to the medicalisation of menopause where symptoms must be treated and treatment is presumed necessary to prevent long-term health problems in women (Coney, 1994). Women need to be monitored, given prescriptions and often surgical procedures to protect them and become dependent on the medical system (Coney, 1994; Greer, 1991). In this model Worcester and Whatley (1992) contend, women are encouraged to see their bodies as dysfunctional and themselves as ill, turning menopause into a disease that reinforces attitudes and myths that reflect gender bias. Furthermore, this model permits and validates symptoms and entrusts the medical profession the mission of caring for the illness.

Indeed, Kaufert and Gilbert (1986) claim this model implies that women are under obligation to seek treatment and physicians are obliged to provide HRT to restore women to normality. As Lewis (1993) points out, some women view HRT with suspicion or fear, whilst other women see a refusal by physicians to prescribe HRT as another example of dismissing women's concerns about their health problems. However Morgan (1998) directs our attention to the fact that by increasing their demand for HRT, women are in fact reinforcing the medical model of mid-life women.

As Crowley and Himmelweit (1992) point out, the medicalisation of menopause (and women's health) over the last 30 years is an extension of the medical sphere where a dominant group can define what is 'normal' under "... a form of power exercised by the medical establishment over the minds and bodies of women through a particular discourse ..." (p. 64-5). As previously argued some feminists, suggest that menopause is used as a profitable ruse for the pharmaceutical industry (Coney, 1994; Greer, 1991; Klein & Dumble, 1994).

According to Coney (1994), the pharmaceutical corporations devised a method to integrate the usually healthy middle-age woman as a component in healthcare's profit making industry. In order to boost sales, pharmaceutical companies have promoted HRT as the choice treatment to protect against osteoporosis and heart disease. In addition, HRT is marketed to relieve other menopausal symptoms such as, hot flushes, depression, insomnia and keep skin smooth and memory sharp (Hunt, 1994). Coney (1994) argues that the 'well' woman is urged to pay for medical treatment when she has no symptoms of illness and in fact, may be passively contributing medicalising women's experiences of menopause. Accordingly, Morgan (1998) writes:

... women's widespread demands for hormonal replacement therapy suggest that, in addition to associating particular experiences such as hot flashes with menopause, women are actively taking up the medicalization model of women's mid life as a potentially dangerous life stage ... (p. 97)

Griffith's (1999) study of women's choices regarding HRT surveyed 566 women, aged 20 to 69 on their approach and what influenced their decision regarding taking HRT. The majority of the women resisted taking HRT except for severe symptoms and were uncertain about the benefits of taking HRT. Fear of illness and ill health influenced many women's decisions yet they expressed interest on information on other forms of therapy. The majority of women revealed that the media was their major source of information on menopause. In addition personal experiences of family ill health and illness made them reflect on their own well-being. Although some of the women expressed ambivalence about the benefits of HRT, they were prepared to take HRT to keep them healthy. Even though this study included women with a wide range of ages and experiences, they still reported the paucity of information on 'normal' menopause. The majority of women based their choices on fear and a medical model of illness reducing their narratives to a medical discourse of menopause.

A similar dilemma was expressed by some women who "... worried that they may be missing out on a future benefit, ..." (Stephens, Carryer, & Budge, 2001, p. 36) by not taking HRT. Stephens, Carryer, and Budge (2001) examined data from transcripts of 80 New Zealand mid-life women and uncovered many concerns including: 'fear of future

regret' and 'getting off HRT'. Analysis of data from this group showed that while some of the women were experiencing no symptoms and were not taking HRT, their concerns were influenced primarily by the medical attention on HRT and the perceived threat of osteoporosis. In contrast, the women who were taking HRT expressed concerns about long term use of HRT and whether their symptoms would return should they stop taking HRT. The authors found:

They both compare themselves with older women who have passed through menopause without the assistance of HRT, but they remain unsure about their own future. (p. 37)

Women's actual and perceived levels of knowledge of menopause are generally obtained from friends, doctors, popular magazines and other sources, which contribute to the women's uncertainty (Clinkingbeard, Minton, Davis, & McDermott, 1999). Despite the plethora of literature and information available on menopause and HRT, many women have difficulty in making decisions on appropriate treatment for their menopausal symptoms. Some women expressed dissatisfaction with the information being offered by their physician (Turia, 1998) or, insufficient information given to make an informed choice (Anderson, 1998); and are confused with the contradictions and uncertainties of information received (Budge, Stephens, & Carryer, 2000). The uncertainties expressed by women in these studies point to the need for balanced, unbiased information and opportunity for discussion in a context where issues such as risks of osteoporosis and long term use of HRT can be broached.

In sum, medical discourses are a significant issue for feminists and for all women, as medicalised perceptions set boundaries on ways of thinking and feeling. Conceptualizing menopause as a deficiency disease pathologises the entire post-menopausal period of a woman's life. In addition, it leaves the intangible problem of having no way to think of women's function other than in reproductive terms.

2.8. Conclusions

This chapter identified a selection of literature on menopause arranged into four discursive fields: feminist, sociocultural, psychosocial and biomedical. Although this literature reflects some views of menopause 20 to 30 years after the time the participants in this study had their experiences, this study will explore the similarities or differences of women's experiences in the context of this literature.

The majority of feminist literature supports menopause to be a universal and normal physiological life event in a woman's life. In addition, feminist scholars deduce menopause to be a product of personal, environmental, social and cultural factors that interact at all levels and exist in historical and political contexts of women's lives. Feminists contend that mainstream medical literature on menopause ignores the many women who have few or no symptoms and overlooks women's psychosocial problems by transforming the problems into illness (Pringle, 1998; Wright, 1998). Menopause as a treatable disease they maintain, reinforces traditional stereotypes regarding menopausal women and as a consequence gives power of control to the medical profession (Fiske, 1993).

The biomedical paradigm views menopause as a deficiency disease and encourages women to become dependent on the medical system, placing them in a vulnerable position as a lucrative market in the male-dominated healthcare system. As a result women, as a relatively powerless group whose values and interests are not well represented or widely accepted are exposed to information that cultivates professional control at their expense. Women in this present study experienced menopause at the point where medical interest in women's mid-life was intensifying but not fully established. As a result, their experience may be different.

In the next chapter I will present the methodology and method used in this study. Feminist epistemology is the underlying framework and descriptive analysis as the method guided this study.

CHAPTER THREE: Research methodology

This chapter explains my choice of a research method underpinned by a feminist epistemology applied throughout this thesis. The first section outlines the key aspects of a feminist approach to research. The remainder of the chapter focuses on describing the method of participant selection, ethical considerations and data collection. Finally, a brief outline of the method of data analysis applied to this study.

3.1. Feminist research

Because women and their experiences are the subject of this study, feminist research as a theoretical perspective will be used. The goal of feminist research as noted by Carryer (1995) is to capture the reality of the experience from the vantage point of a particular group of women in order to address situations, which characterize women's lives.

According to King (1994) feminist research "...refers to research questions that are pertinent to women, and of interest to women," (p. 20). For Parker and McFarlane (1991) "...feminist methodology begins by selecting a problem to be studied that relates to all women." (p. 61). Another view by Oakley (1993) proposes feminist research to mean research that relates to an understanding of women's position as that of an oppressed social group, and which adopts a critical perspective toward traditions and assumptions rendering women either invisible and/or subject to stereotypical categories.

According to Reinharz (1992) feminist research must include three criteria. First, the research must document the lives and activities of women; second, it must understand the experience of women from their viewpoint; and third, it must offer a way of conceptualizing the reality of the women's lived experiences. In this way, feminist research validates women's experiences, allows women's voices to be heard, and provides a written record of women's experiences.

Seibold, Richards, and Simon (1994) suggest the core of any feminist research must take account of women and their experiences as the major core of any study of women. Further, they argue feminist research must include discourses of women's lived experience and the ways women negotiate the world around them. Hall and Stevens (1991) take this point further in stating that feminist research must include the concept of what it means to be a 'woman' occupying a certain role.

Harding (1996) emphasizes the crucial role feminist research plays in developing an understanding of the social, political, economic, and cultural forces that affect women's opportunities for health and well being. According to Sigsworth (1995) feminist scholarship must be oriented toward the improvement of women's status and should be undertaken by scholars who define themselves as feminists, that is, the researcher is engaged rather than value-free. Additionally, she reasons that by giving women an opportunity to articulate their lived experience, this experience develops into a legitimate source of knowledge. Reinharz (1992) supports this:

When feminist oral histories cover extensive portions or profound experiences in an individual's life, they assist in a fundamental sociological task – illuminating the connections between biography, history, and social structure. (p 131)

As Stanley and Wise (1990) indicate, there is no one set of qualitative methods that is seen as distinctly feminist and not one feminist perspective that encompasses the diversity of women's experiences. However, they stress there are clear differences in feminist frameworks, for example social, radical, liberal or poststructuralist in which the researcher may position herself. Feminist epistemology encompasses the many ways that values, politics, and power relations are connected and what influence these have on the construction of knowledge. Oakley (1993) argues that women's experiences need to be acknowledged as a valid 'form of knowledge because women's experiences are embedded in an ever changing complex social context. Stanley (1990) argues for a new epistemology "...in which 'knowledge' is not simply defined as 'knowledge *what*' but also 'knowledge *for*' (p.15).

The personal, social, and political meaning women make of their bodies is primarily a social construct. There is considerable feminist literature that argues critically that the concept 'woman' is itself problematic in so far as it hides differences within and amongst women, such as ethnicity, class, and disability (Thompson, 1994; Tong, 1998).

In keeping with the feminist approach to this research, attention must be paid to the social and institutional contexts of women's lives in order to address power relations. As Dickson (1990) cautions, feminist discourses and women's experiences are embodied as "... the result of competing power relations"... (p. 23). From a feminist perspective, I will extend the point of reference of menopause as the consequence of physiological changes and instead emphasize a discourse of exclusion. By using the term exclusion I imply how women's suffering is not solely caused by any physiological symptoms women may experience during menopause, but rather by the culturally imposed discourses of marginalization which determines the destiny of women's bodies. In other words, by placing emphasis on the physiological symptoms of menopause and defining it as a 'disease', women's experiences of menopause have been silenced and dismissed on one hand and yet made the subject of excessive medical interventions on the other hand.

In order to understand menopause from a feminist perspective, it is necessary to see menopause in the context of culture – a culture which limits and prescribes women's behaviour in many ways, and which perpetuates sex-based inequities in economic and political power through the dissemination of myths about women's 'natural' role

Traditional science is embedded in a cultural discourse that describes some human attributes as normal and natural, and others as anomalous and in need of explanation. Where others differ from the norm, they are viewed as problematic and in need of investigation and correction (Harding, 1996). This study underpinned by a feminist framework attempts to explore menopause in a time where women's lives were lived in a socially different context including potentially less impact from medicalisation.

3.2. Method

In an effort to make sense of gathered data and to capture the richness of the women's narratives of their experiences, I asked the question – what is this study of? This study describes older women's previous experiences of menopause as it happened to them in their own words. Thus, it made sense to present the data in a descriptive form in order to provide a portrait of events as they naturally happened.

Qualitative descriptive research describes events and individual's varying perceptions of the world; in other words, what one believes about the world (Burns & Grove, 2001). Taylor and Bogdan (1998) support a descriptive approach as a method of study in qualitative research as descriptive studies illustrate "... a picture of what people say and how they act in their everyday lives." (p.135). Accordingly, descriptive studies allow a researcher to systematically describe events as they occurred in a natural environment. The researcher accumulates data that is solely descriptive with no effort made to explain or interpret any hidden meanings about the event.

As Seaman (1987) indicates, qualitative descriptive research methods seek "...to describe accurately the characteristics of an individual, a situation, or a group portraying them as human beings rather than study objects." (p.182). Additionally, a specific phenomena such as menopause "... may be studied to illustrate patterns of both illness and health, thereby casting light on what is 'normal', or what is considered 'wellness'." (p.182).

Sandelowski (2000) encourages researchers to adopt descriptive studies as "... the method of choice when straight descriptions of phenomena are desired." (p. 334). Sandelowski (2000) suggests that qualitative descriptive studies are creative and interactive because the researcher interacts with the data and stays "... close to the data and to the surface of words and events ..." (p. 336). Qualitative descriptive designs focus on capturing the subjective experience of individuals through a systematic process of data analysis directed toward – what is happening here?

In the following pages, I will present how I applied my choice of descriptive qualitative research as the method used in this study.

3.2.1. Participant selection

A convenience sample of 10 women aged 70 years and over were asked to participate in this study. The criteria used for selection required the participants had to be aged 70 years and over in order to position them in the period of 'doing' menopause 20 to 30 years ago. Participant numbers were limited to 10 as Brink and Wood (1988) suggest, a group of 10 participants is a satisfactory size for an in depth study using qualitative research. An advertisement / flyer (Appendix A) was placed in my local newspaper and in the local women's club and community centres. The decision to recruit participants locally was based on pragmatic matters involving geography and finances.

In contrast to assurances that advertisements are an effective tool in which to assemble volunteers as participants (Taylor & Bogdan, 1998), it proved to be more of a challenge than I anticipated. I waited patiently for my phone to ring for over a month, before I became concerned. I repeatedly visited the centres at the time when older women would be present. I engaged in discussion with a few older women in an attempt to explain the purpose of my research. The majority of time, the women explained to me that they really had nothing to contribute, but at the same time they sat with me and began to tell me their experiences. I quickly explained to them that my study had to follow a strict process including informed consent and that we would have to arrange an interview time. Even though they appeared to dismiss my concerns, they agreed to formalize the process.

Participants were also recruited by means of a snowballing technique in which some of the participants provided me with the names of women who were interested in being interviewed. This method proved to be more satisfactory as one woman encouraged another to tell me their experiences. Ten women aged from 73 to 84 volunteered to participate in this study. All the women except for two, who remained married, were living alone. All the

women at one time or another had been married and two were in second marriages. All the women had children and seven women had daughters. Only one participant had surgically induced menopause following an abnormal pap smear.

3.2.2. Ethical considerations

Prior to commencing this study, approval was obtained from the Massey University Human Ethics Committee. Ethical considerations, such as right of privacy, issues discussed in consent, the right to decline to participate, confidentiality and rights and responsibilities are discussed subsequently.

In this study each participant was given an information sheet (Appendix B) that included a description of the study and outlined the purpose of the study in simple terms. Time was allowed before the interview to clarify any details or answer any questions from participants. The provision of information on which consent is based has to be clear and well defined so that it does not overwhelm or confuse those whom it is intended to inform (Taylor & Bogdan, 1998). Valid consent to participate in the research is dependent on full understanding and freedom from coercion and deception. Participants were then asked to sign a consent form (Appendix C) to agree to participate in the study. Consent included permission for the interview to be audio taped. Permission was also received to use material provided after the tape was turned off and any notes made in my journal. The participants were also made to understand that they were at liberty to withdraw from the study at any time.

Participants have the right to expect that the researcher will not divulge confidential information. Polit and Hungler (1997) emphasize that a promise of confidentiality to participants is a guarantee that any information participants divulge, will not be reported or made accessible to anyone other than those involved in the research unless all identifying features have been removed. Anonymity provides protection to participants against being identified in the data or the report. In this study pseudonyms were used on data to prevent

accidental breach of anonymity. Demographic data will not reveal any details on specific individuals. Raw data was transcribed by a secretarial service that was asked to sign a confidentiality agreement (Appendix E). Raw data, participant's identity, computer disks, and audiotapes were safely stored in a locked filing cabinet. Precautions were maintained to ensure participants were protected from potential harm or discomfort by allowing the participants to freely discuss their experiences without intrusive questions.

3.2.3. Data collection

According to Brink and Wood (1988), interviews allow the researcher to observe responses of participants and provide depth and richness to data. Semi-structured interviews allow participants the freedom to bring issues to the surface as they choose. According to Taylor and Bogdan (1998), in-depth interviews are:

...face-to-face encounters between the researcher and informants directed toward understanding informants' perspectives in their lives, experiences, or situations as expressed in their own words. (p.88)

As Oakley (1981) suggests, an interview may involve risk for both the participant and researcher. The risk for exposure is often one-sided in the interview situation, when both the researcher and participant knows the focus of analysis will be on what the participant says. As long as the researcher asks the questions, records the responses and decides on how to analyze the data, the balance of power remains firmly in the researcher's hands. The interview experience holds a potential for trust and commitment or the potential for abuse or betrayal. In agreeing to being interviewed, the participant is showing trust and hope that the researcher will be true to the experience and to the participant.

In this study, the method of collecting data through semi-structured interviews allowed me to direct the interview but at the same time, allowed the participant to be open to whatever she wanted to say. I encouraged the participants to talk freely and to express their thoughts on their experiences. Moreover as Polit and Hungler (1997) emphasize, in allowing "...the respondent to tell their story in a naturalistic, narrative fashion" ...(p. 255), data collection

captures all the relevant aspects of a life experience. I was less concerned with dialogue about potential post-menopausal conditions such as osteoporosis or consequences of HRT use and more interested in the psychosocial aspects of menopause. As a consequence, a list of prompt questions (Appendix D) allowed me to direct the participants' thoughts on their experiences, paying particular attention to their relationships with members of their families and with other women. All interviews commenced with one open-ended question, 'Can you tell me about the time you knew or believed yourself to be in menopause'. Probing questions were included to ensure that certain areas were covered in the interview such as, whether or not the participant had ever taken HRT or been offered any options regarding management of their menopause.

My identity as a nurse may well have placed me in a position of power as one with knowledge. In addition, as a nurse I was conscious of my need to offset any bias in the interview process and to establish an egalitarian relationship to allow dialogue between the participant and myself. Another way that I attempted to reduce the unequal power relations was encouraging the participants to take the lead in what they would like to talk about. This did not always work and I found the majority of participants wanted to be asked questions so that they could give 'correct' replies.

Interviews were arranged in places suitable to the participants and they all took place at the participant's home. Interviews lasted no longer than one hour and time was allowed before and after the interview to respond to any questions or comments from participants. Generally, discussions were easy and required a minimum of direction.

Following an explanation on confidentiality, the information sheet was discussed and each participant signed a consent form. All interviews were audio taped in order to capture women's experiences in their own words. In addition, I made notes in a personal journal during the interviews, with permission from each participant, to highlight significant comments and at the end of each interview as soon as I was alone to record my own thoughts and feelings.

3.2.4. Rigour

While a variety of research literature has described ways to arrive at issues of rigour in qualitative studies, feminist research literature addresses the need for three criteria to be used for establishing the trustworthiness of qualitative data: credibility, dependability and reflexivity (Carryer, 1995; Hall & Stevens, 1991; Polit & Hungler, 1997; Sigsworth, 1995; Stanley & Wise, 1990; Tolich & Davidson, 1999; Webb, 1992).

Dependability assures that data obtained in the course of the research provides a reliable basis for accepting the data as a true representation of data collected (Mays & Pope, 1995). Dependability was demonstrated by the systematic collection of documentation and material related to the study in order to develop an audit trail to allow an independent auditor to follow the analytical process (Mays & Pope, 1995). Extensive documentation of interview conversations, reading and re-reading of transcripts and participant feedback has been integrated within this study as means to ensure that I have clearly heard and understood what the participants are telling me. In addition as this study is underpinned by a feminist framework, I acknowledge this the analysis is no means a single reality of older women and their previous experiences of menopause. As Seibold, Richards and Simon (1994) explain:

... a feminist perspective emphasizes the uniqueness and contextualized nature of women's experiences, and interpretation within this context, rather than their standardization and repeatability. (p. 399).

Reflexivity has been defined by Lamb and Huttlinger (1989) as a way of thinking

...in which an investigator seeks to understand how personal feelings and experiences may influence a study and then strives to integrate this understanding into the study. (p. 765)

Reflexivity requires the researcher to reflect and acknowledge her own experiences and cultural beliefs in order to judge and evaluate what has occurred. Reflexivity "... goes beyond setting aside personal beliefs that may contain bias." (Lamb & Huttlinger, 1989, p. 768). As Tolich and Davidson (1999) write:

Reflexive research reflects upon and questions its own assumptions. Researchers must self-consciously reflect upon what they did, why they did it, and how they did it. (p. 39)

During data collection and data analysis, I was conscious that my identity as a nurse and my personal experience of menopause should not overshadow the women's narratives. Throughout the study I reflected on what influence if any, my personal position on menopause would have on my ability to hear the women's experiences.

During data collection and data analysis, I reflected on what happened before, during and after the interviews. Before and after each interview, I reflected on whose interests were being served here? Prior to each interview I spent time answering questions about the research process and research topic. I was conscious that after each interview and as I became more comfortable with the process, I demonstrated confidence and knowledge and became more aware that I was not an expert on the topic and not to present myself in this way. I assured all the participants that I would send them a synopsis on completion of this research.

How do I know what I have described is worthwhile? Before the interviews, the majority of the participants explained that they believed they had nothing to offer to this study yet; they took a risk and placed their trust in me to share their personal experiences with a hope that somehow their contribution will add to this study. After the interviews, I reflected on particular anecdotes that participants shared after the audiotape was turned off. As I reflect on these moments, I was aware of the importance of preserving my personal journal notes in order to be true to the women's actual experiences. My personal journal also gave me the ability to document my thoughts on women's narratives and compare these with my own experience of menopause. I recorded questions that some of the women had asked me, 'What was my reaction to menopause?', 'Why has menopause become such an issue for women today?', and 'How does my story compare with the other women?'. From the beginning of this study I was conscious that this study was not just a research, but a story about some women's lives and in some way because I am a woman, a record about my life.

Mies (1983) suggests reciprocity is realized when the researcher offers the participants some aspects of their own experiences at the end of the interview. After the interview, the majority of the participants inquired about my own experience of menopause and what my motivation was in choosing this topic. I was asked about other women's experiences in my clinical practice and three women asked whether or not their experiences were the same as other participants. Their questions engaged us in a spirited dialogue about women's health and as four of the participants were nurses, what responsibilities nurses have in the education in menopause. Feminists choose reciprocity in order to try and give something to the participants so there is mutual benefit from the research process.

In keeping with feminist methodology, which seeks to leave a high level of control with the participant, I returned a copy of the transcript to participants to enable them to read and / or make any changes. I followed this up with a phone call, a week after I posted the transcripts. All the participants agreed to continue with the research and no one made any changes or deletions.

3.3. Data analysis

According to Field and Morse (1995), the purpose of data analysis is to enforce some order on a large body of information so that some general conclusions can be reached and communicated. In order to construct an analysis, which goes beyond the experiences of participants while granting them subjectivity, Sandelowski (2000) suggests that the data be allowed to speak for itself. In other words, it is imperative to describe the women's experiences as accurately as possible in order to remain faithful to the women's narratives. Dividing the data into categories allows me to analyze the data into the first level of inquiry, which asks the question, 'What is this?'

Data analysis is central to the data collection process as it involves the search for words or phrases or descriptions of events from the view of the participants (Field & Morse, 1995). According to Sandelowski (2000), qualitative content analysis provides a systematic

process of analysis by accurately reflecting the attitudes, interests and values of women's experiences in a naturalistic account as the participants presented them. Qualitative content analysis presents the means of measuring the frequency, order, or intensity of words, phrases, or sentences. Data is analyzed by comparing key words or phrases, placing the data into categories, and naming the categories taking into consideration the contextual milieu of the data in order to bring to life the women's experiences of menopause.

Transcripts provide a descriptive record of interviews and the researcher needs to review data for content consequently transforming qualitative data into units of analysis. As the first seven interviews were transcribed by a secretarial service, I checked each of the completed transcripts by listening to the audiotapes and noting any omissions or errors. I transcribed the last three interviews and I was startled at the variance with those transcripts. I became more absorbed with the data and I was able to decipher the data with greater clarity through recollection of conversations with the participants. In addition, I was conscious that these were the last interviews and both my skills and confidence as an interviewer had improved.

Transcripts provided a descriptive record of interviews and allowed me to review the raw data in a search for key words, phrases or descriptors of meanings, practices, relationships, lifestyles, roles, socialization or knowledge of the research topic (Field & Morse, 1995). Each transcript was reviewed and the audiotapes were listened to several times. Patterns were highlighted and compared across the transcripts, thus enabling me to identify similarities and differences across the transcripts.

Once the transcripts were analyzed, expressions were condensed to a page per participant. The expressions were examined for similarities and differences and coded into ten categories initially. Each category was allocated a colour and the transcripts were again analyzed for key expressions. This resulted in some expressions to be linked to another category and some expressions were reallocated to another category and the category number was reduced to eight. The colour-coded transcripts were cut up according to category and pasted on a large poster. Burns and Grove (2001) describe the coding process

as the "... simplest method of classification ..." (p. 599) involving the bringing together and analyzing all the data into categories. Once the codes were organized and compared, the data was again reviewed to identify any words or phrases that related to the specific categories. The codes were then physically organized into eight themes: meaning; knowing-confirming; worry-anxiety; relief-release; adaptation-adjustment; support-counsel; illness-malaise; options-power to choose, to form a comprehensive picture of the data.

In summary, the process of data analysis is a putting together, making connection, and interrelating units of analysis until patterns of consistent events can be illustrated and supported by the data (Taylor & Bogdan, 1998). According to Sandelowski (2000):

The expected outcome of qualitative descriptive studies is a straight descriptive summary of the informational contents of data organized in a manner that best fits the data. (p. 338-9)

The findings of the analyzed data are recounted in narrative form in the next two chapters. Verbatim narrative from transcripts and field notes are incorporated to link the data to the appropriate literature resulting in discussion and conclusions.

3.4. Summary

This chapter described the particular approach used in data collection and my choice of qualitative descriptive research. A qualitative descriptive study provides a holistic method of capturing and describing older women's subjective experience of menopause. Qualitative content analysis in this study resulted in two categories and eight themes of descriptors of the research topic using participant's own words and experiences. The goal of this study is not to seek to generalize older women's experiences of menopause to all women but to provide a valid description of this group of women's experiences of menopause as it was 30 or so years ago.

This concludes the introduction and background to the study. In the next two chapters I will present detailed discussions of the findings from this study and in the context of the available literature. The eight themes will be presented in the following chapters under the

two categories of 'achieving-recognizing menopause' and 'connecting-engaging with menopause'.

CHAPTER FOUR: Achieving-recognizing menopause

In the next two chapters I will present the findings from the transcripts of the women's interviews. In keeping with a qualitative descriptive method, the analyzed data will be supported with examples of the women's narratives and compared and contested with a selection of existing literature on menopause.

In this chapter I will introduce the participants and explore four sub-themes from the study: meaning; knowing-confirming; worry-anxiety; and relief-release.

4.1. Introduction

The participants in this study are Ann, Mary, Joan, Judith, Catherine, Elizabeth, Victoria, Agnes, Helen, and Doreen aged from 70 to 84 years. All the participants have been married at one point in their lives and Ann has been married for 62 years. Joan and Elizabeth have married for the second time, Mary has been separated for many years and the remaining women are widows. Between them, the women have 24 children and of those 13 are daughters. Agnes is the only woman who had surgically induced menopause when she had a hysterectomy and bilateral oophorectomy at 54 years of age and believes her menopause "*was not the normal run of the mill*". Joan, Judith, Catherine, and Victoria are retired nurses and believe they have an adequate knowledge of menopause.

Even though Joan had a hysterectomy, her ovaries were left intact and she experienced a 'natural' menopause. Joan was the only woman able to give an exact age when she believed she was in menopause and the other women cited a range of ages from 47 to 55 years of age. This range of ages positions the women as experiencing menopause 24 to 35 years ago, in the mid-1950s to the late 1960s.

4.2. Meaning

The purpose of a qualitative study by Jones (1994) of middle-age women and their experience of menopause, was to increase our understanding and knowledge of women's bodies and what effect if any, their knowledge had any influence on their experience of menopause. According to Jones (1994) the aim of the study was to examine if changes in women's behaviour and attitudes were motivated by their experiences of menopause. Jones (1994) found that a woman's 'experience' was dependent on what her 'understanding' of menopause was. However what Jones (1994) found, was that a woman's experience was dependent on the 'meaning' a woman associated to her menopausal experience. The women in her study understood menopause to represent significant physical changes in their bodies and in their lives. The majority of the women "... described their menopausal and post-menopausal bodies as deteriorating and generally in decline, ..." (p. 60) and "... had internalized the established medical narrative and were struggling to create new ones" (p. 60). Jones (1994) research illustrates one example of the continuing influence of the biomedical perspective on women's experience of menopause.

The majority of the women in this study acknowledged menopause to be a "*natural and normal*" biological event signifying "*no more periods*". Judith understood menopause to be a transitional period, "*those years are over and you're into another set of years*". Catherine believed she would "*become infertile*" and Elizabeth suddenly realized that "*I can never have another baby*". Helen described menopause as "*something that happens, ... a natural part of living*" and Doreen clarified that it "*happens to all women*". The only negative meaning of menopause was given by Mary:

Just another difficulty to overcome, just one of those things in life that women just expect and deal with when it comes. (p. 1)

The majority of the women made the connection between menstruation and menopause and expressed delight that menopause signaled an end to menstruation.

I was pleased to be through having periods every month because that was a miserable time for me (Mary, p. 3)

... I felt I'd be a lot freer without having periods. (Catherine, p. 2)

... finally stopped having those periods which were a nuisance ...(Elizabeth, p. 1)

...you have more freedom because you don't have to think 'oh will I have my period while I'm there' (Catherine, p. 3)

My periods were always a problem. I was still having these periods ...
(Agnes, p. 1)

Menstruation was a popular topic of discussion among all the women. Agnes was aghast that she was still menstruating at 54 years of age which was rather fascinating as menopause is a process that spans five to seven years and usually affects women from the age of 47 to their mid-50s (Sheehy, 1998). The majority of the literature indicates that there are no clear age indicators as to when this changeover begins or when it ends (Lock & Kaufert, 2001).

...I was slightly embarrassed if they even knew I was still getting my periods, ... I never told anyone that I was over 50 and still getting my period. They thought that I had gone through my menopause. I didn't tell anybody. (Agnes, p. 3)

For some of the women, the cessation of menstruation meant freedom from fear and worry about pregnancy

... able to go on with life and without the anxiety of thinking I would have more family. (Ann, p. 3)

... when the menopause comes I won't have to have any more worries, ... you don't have to take any precautions. (Victoria, p. 3)

... no possibility of more children, but that did not worry me at all, ...
(Helen, p. 1)

Freedom from menstruation and worry about pregnancy are similar meanings expressed by woman in recent literature in relation to menopause (Forster, 1994; Siegal & Doress-Worters, 1994). Agnes was the only woman who described her reaction and her anger when she realized she could have no more children:

... because I thought I could not have any children. Now this is ridiculous thinking about this at 54. Now I would not want one anyway. Now what was I thinking about? But because I couldn't have a baby anymore I wanted, I

didn't want to be cut off in case I change my mind and now I can't. And I really felt quite angry about it. ... I felt well, it's not fair. (Agnes, p. 2)

Agnes's reaction and grief over the loss of her reproductive potential can be linked to women and their roles thirty years ago (Spitzer, 1995). The loss of childbearing potential signaled a loss of woman's status as a mother and her place in Western society. Although Agnes acknowledges that a hysterectomy brought an end to her problematic menses, she arrived at an understanding that her anger was not based on her personal loss as a 'child bearer', but was based on her personal loss to 'choose'. Agnes believed that unlike women who have a 'natural' menopause, she "*was shortchanged*" as an outcome of her hysterectomy. Greer (1991) suggests that for many women, menopause is a time when a woman comes to terms with her own mortality and for some women, it can be a time that they mourn the loss of their reproductive powers.

In '*The second sex*', deBeauvoir (1989) describes menopause as a phase in a woman's life when a woman is deprived of her femininity. Sheehy (1998) claims some women suffer an identity crisis during menopause. Greer (1991) suggests menopause brings the awareness of yet another message for women as they struggle with their 'new invisibility'. Some women catch sight of the full breadth of their life events including ageing and some of the psychosocial issues around ageing relevant to their experience of menopause. Catherine's attitude to menopause was expressed in philosophical terms, "*... just a part of growing older ...*". In contrast, Joan and Agnes describe their menopause in relation to their thoughts of reproductive femininity.

... you think you've lost something. You're no longer a woman ...
(Joan, p. 4)

Isn't it incredible when you think about it , it must be something, something that is feminine in your brain or your psychological psyche or something or other that makes you feel that just because you can't have any more children, well then therefore you are not a whole woman anymore. (Agnes, p. 2)

Lindsey (1997) asks, can women accept that biological processes such as menopause, have no bearing on women's perception of a 'real' or 'normal' woman is. Whilst, Agnes

expressed concerns about her identity in relation to menopause, she was able to cast doubt on what any perceptions others may have made of her:

... do they think my nature or my personality or, anything really changed?
(Agnes, p. 4)

In sum, the majority of literature on menopause argues that menopause is associated with a variety of meanings and theoretical considerations. The dynamics of personal meaning are dependent on the symbolic constructions of menopause in relation to women's roles and context of women's lives. These women appear to express a considerable range of responses to menopause just as women do now – is there a difference? The majority of women in this study perceive menopause as a normal physiological event and something that happens to all women.

4.3. Knowing-confirming

The physiological changes that a woman experiences in mid-life are recognized to be the precursors in determining if a woman is in menopause. The biomedical model presupposes a woman to be in menopause based on alterations in her menstrual pattern and the onset of hot flashes (Utian, 1980). According to Sheehy (1998) change in menstruation is the first sign of menopause rather than hot flashes which some women may experience during perimenopause.

How can a woman find out if she is in menopause? According to Utian (1980), a simple blood test confirms whether a woman is in menopause. Although little research has sought to find out what the effects FSH and LH levels had to do with changes in menopause, this method according to the biomedical model, is deemed to be a conclusive 'diagnosis' of menopause. However, a study by Dietsch (1995), uncovered 32 per cent of women aged 15 to 19 years and 46 per cent of women aged 15 to 39 years reported similar symptoms that were attributed to oestrogen deficiency. These implications reveal there are no universal, characteristic patterns to give an exact picture on the exact 'time' of when a woman is in menopause.

A study by George (2002) found, that the majority of women were confused about the changes that would signal the onset of menopause. Some women did not experience any hot flushes or were unaware of them and the majority of women assumed their menses would suddenly come to an abrupt end. Quinn (1991) found women were uncertain that any of their bodily changes they were experiencing were actually related to menopause. Anderson (1998) found that every day life stressors were blamed as the cause in menstrual alterations by some women and causing some uncertainty in women as to what they were actually experiencing was attributed to menopause or they were going through 'a bad time'.

Mary, Judith, Doreen and Helen describe similar typical symptoms of menstrual irregularities as indicators of 'knowing' they were in menopause:

... my periods started diminishing and I was getting hot flushes ...
(Mary, p. 1)

Slight irregularities of the monthly flow which had always been regular and then it just ceased, it gradually ceased until there was really nothing.... Oh yes I knew it would come. (Judith, p. 1)

... my periods were going funny, ... sometimes I would get a flush, my neck and face would get red, ... my husband would ask – are you alright?
(Doreen, p. 1)

The night sweats, ... I didn't have to get up to change the sheets or my clothes, but really I was sort of sweating and I couldn't understand it, till I twigged at what was really going on. (Helen, p. 1)

Victoria described how her difficulty with menstruation as being the reason her doctor prescribed the birth control pill as an attempt to control her breakthrough bleeding. She took the pills for two years and one day:

I thought why am I taking this pill. I don't want it anymore and it was just before Christmas I took the last lot. I didn't take another pill, I never saw another period, I had no more problems. That was the end of everything, I couldn't believe it. (Victoria, p. 1-2)

More than half the women in a study by Dickson (1990) reported never experiencing any hot flushes, causing the women to question whether they were actually in menopause. As

their knowledge was based on scientific / medical literature, the women were left to wonder if they actually were in menopause. Similarly, Quinn (1991) found some women, who have been exposed to medical explanations and negative stories about menopause, created uncertainty about their own experiences as being legitimate and genuine.

Elizabeth and Catherine were the only women who had their menopause confirmed by a medical practitioner. Elizabeth was married to a physician and explained that medical matters were a part of her every day life. She had great confidence in her husband's role as her minder of health and trusted him implicitly. When she became worried about the possibility of pregnancy, he "*decided to take me off to a gynecologist*" where she was assured that she had "*nothing to worry about*" meaning that she was in menopause and had nothing to worry about. Catherine visited her doctor when her "*funny feelings*" started:

I wondered if I was ill or something was wrong, but then I did mention to my doctor and he said , oh well it's menopause. That's the only time I think we ever discussed it. (p. 1)

Mary explained that doctors did not offer any information to patients unless they specifically asked. Although she was under medical supervision for another health matter, she never discussed menopause with her doctor and he never asked or discussed it with her. Agnes lived overseas for a few years and compared her experiences of the medical profession overseas and in New Zealand. According to Agnes, the differences were very apparent notably in the doctor-patient relationship. Overseas, patients were encouraged to ask questions and engage in conversation with their physicians; "*In New Zealand the psyche is that you don't ask, you do as your told.*" (p. 4).

The majority of women in a study by Budge, Stephens, and Carryer (2000), reported a lack of trust and confidence in their doctor's opinions as medical indecision could not authenticate their experiences as menopause. The women voiced uncertainty about the information they received about menopause and expressed concerns on whether this information was objective and unbiased. Biomedical knowledge is dominant in the sense of being the most valued and authoritative and as a result Smith (1998) notes, "... women's opinions are sharply separated from their lived experiences." (p. 35).

Helen “*made it my business to find out how and why*” (p. 2) and became proactive by listening to the radio talk shows and purchasing a book that she calls her “*bible*”. Doreen’s menopause was confirmed by a friend and at the hospital where she was a volunteer:

... we chatted with most of the nurses – the nurses told her first and then when I asked them, they told me I was having the same. (p. 1)

The majority of women opposed the view of menopause as an illness and revealed their main source of information on menopause, was primarily from their friends and not from medical professionals.

... we would talk to one another about that sort of thing. (Ann, p.2)

Mary describes a situation when she was able to pass on some of her knowledge:

... I had a strange little conversation with someone when I was in my thirties, with a friend who was about 15 years older and she took me aside one day and said, ‘when all your periods stop, does it all close up’ she said, [husband] wouldn’t stay with me. So that’s the kind of ignorance there was, but I did know enough to tell her there was nothing to worry about. (p. 2)

In this study, none of the women had ever discussed menopause with their mother however, two of the women remembered their mother being “*very irritable*” and “*having terrible hot flushes*”. Similar comments can be found in a study by Beasley (1999) which included narratives from four women, aged 70 years and over, indicating menopause to be a taboo subject, not discussed with friends. Helen and Agnes supported this view of menopause:

It was not discussed much. ... among women my age. We made passing reference to it, that’s all. (Helen, p. 3)

... it’s only a new thing, this talking about personal, like menopause, ... it did not happen in my generation. (Agnes, p. 5)

New Zealand research by Turia (1998), Anderson (1998) and Stephens, Carryer, and Budge (2001) indicate that today’s women draw their information about menopause largely from friends and mass media. Since these views are strongly negative, women have come to expect problems in menopause and are mystified when they in fact do not experience any difficulties in menopause. Similarly, the majority of women in this study recognized menopause to be a biological event and something that was expected. Although several of

them experienced a variety of menopausal symptoms, they were recognized to be a part of the process of menopause.

4.4. Worry-anxiety

The medical model regards menopause as a period of crisis, where a deficiency of hormones creates chaos in women's physical and emotional well-being. Accordingly, the lack of hormones causes a disruption in body temperature, a reduction in bone density, atrophy of sexual tissue and can be associated with psychological distress (Wilson, 1966). As a result the medical model suggests, women suffer from hot flushes, brittle bones, a lack of interest in sexual activity and experience higher incidents of depression, anxiety, memory loss and uncontrollable moods (Sheehy, 1998). The medical model suggests that menopausal women are reduced to a universal multiplicity of symptoms and are eternally trapped in deteriorating mid-life bodies (Cousins & Edwards, 2002). Based on this, one can speculate that women have a lot to worry about.

In contrast to the biomedical model, the majority of women in this study described differing experiences:

I had no pain, I had no headaches, I had no bad tempers. ... I really experienced nothing that could disrupt my life ... (Judith, p.1)

... well sometimes when your face went all red and you felt a bit embarrassed, but not really, no you just carried on with what you were doing, feeling like, Horrible for about 5 to 10 minutes ... (Helen, p.3)

Even though Ann experienced some physical symptoms during menopause, she was worried about the "anxiety of having more family". Ann describes how she became pregnant at 48 years of age, 12 years after she thought she had had her last child. Following this, she worried about this possibility every time she missed a period. She explains:

... I used to get very irritable at times, ...I might have had a few nerve tablets to take, to sort of quieten me down a bit ... (p.1)

Mary likened her irritability during menopause with the similar feelings she experienced during menstruation. She explained how she didn't "*think about the things that are actually wrong*" with her as she "*was on my own running my home, working hard*" and had little time to dwell or worry about things. As a nurse, Joan knew what to expect however,

... you're supposed to have hot flushes and things but I can't remember having hot flushes really. They all said you were going to get them, ... (p.2)

Anderson (1998) described how some women have become vigilant about their bodies and worry if what they are experiencing, is 'normal'. Agnes takes a theoretical approach to their concerns:

...I think a lot of it is all in your head. I think a lot of it is psychological, I think first of all you have to think, my opinion, menopause, nothing unusual, perfectly normal. ... all around people are saying, oh this, the other thing. I am going to get my period any moment and I am feeling depressed and I am angry, I am this, that and the other thing. Are they really or are they talking themselves into it? ... that they really believe they are having a problem and ...they are not having a problem at all. (p. 4)

Certain subtle assumptions and biases about mid-life women are widely reflected in menopausal research, yet too little attention has been given to the reality and variation of women's lives. As it has always been throughout women's lives, increased responsibilities, the break-up of a marriage and greater needs of significant others are some of the complex activities in which women are engaged in (Berger & Forster, 2001).

*... I was going through such a big change anyhow, into a second marriage
(Elizabeth, p.2)*

Doreen had the burden of taking care of her husband who had cancer and explained how she "*did not have time to think*" about any menopausal problems she may have experienced. Her matter of fact attitude describes her situation:

I thought, good, I am not dying or my body is not burning ... (p.2)

... it's not as if the flushes were like a sickness, like vomiting or pains in the body ... (p. 3)

Mid-life women are aware that their bodies are changing, but this process does not start and end with menopause or is a problem unique to women (Greer, 1991). The majority of women in this study acknowledged menopause to be a time of physical change rather than a time of deterioration as is the emphasis in recent literature (Gullette, 1997).

... just a part of growing older and I just took it for granted.

(Catherine, p. 3)

*There was no need to think about it at all really. You knew it was happening.
... you knew what was going on ... (Helen p. 2)*

Biomedical discourses on menopause are dominated by a stereotype of the menopausal woman that denies the varying roles and experiences of the women in this study. The tendency to attribute women's fears solely on physiological symptoms of menopause rebuts their individual experiences. Half the women in this study expressed worry about the possibility of pregnancy as their primary concern in sharp contrast to the medical model assumption about women's disturbances as physiological in nature. The women in this study appear to describe a variety of menopausal symptoms similar to those described by women today. The difference seems to be view their experience as a natural course of events and more accepting of their bodily changes and not focusing on each symptom.

4.4. Relief-release

The biomedical paradigm suggests a woman's sense of meaning in life is linked to her reproductive ability and any expressions of loss or grief are the end product of menopause (Utian, 1980). As menopause approaches, many women in Western society experience, with intense awareness, the limited time ahead. A re-assessment of one's life is in order. However as Greer (1991) points out, all women are not the same and more and more women know that the door is not closing and that life goes on.

Some literature describes how some women in Western society associate menopause with ageing and mourn their loss with regrets (Lee, 1998). Other literature on menopause

suggests that menopause as a symbol of the end of women's fertility, is most distressing for women who occupy traditional gender roles. The discontinuation of menses with the congruent loss of fertility can be intensely felt when menopause is due to surgery, as in the case of Agnes. However, for women who have longed for personal fulfillment and opportunity for new interests, the cessation of menses can be liberating (Defey, Storch, Cardozo, Diaz, & Fernandez, 1996).

The women in this study each gave birth to one or more children and the majority occupied the traditional role of housewife and mother for a period of time at one point in their life. As previously discussed, the majority of the women expressed concern about unwanted pregnancy. However, the majority of the women expressed extreme relief when they were released from the burden of menstruation.

I was relieved when it was over ... (Ann, p.5)

I was pleased to be through periods every month because that was a miserable time for me. I had heavy loss and ... heavy breasts and I found at least 10 days of the month very difficult, so it was a good thing. (Mary, p.3)

... I was weak, so really it was the best thing that happened to me. (Joan, p. 3)

Although the topic of my study was menopause, I was quite fascinated with the women's narratives of their experiences of menstruation. Judith describes her memory of her first period:

I wondered what the hell I remember that happening to me far more than anything else really. That was the trauma. (p. 2)

Both menstruation and menopause bring physiological and hormonal changes in a woman's life. The women in this study separated the effects of the menopausal changes and menstrual changes in their lives. The changes the women associated with menopause varied in intensity but the majority of women developed a spirit of resilience that they learned through their personal experience of menstruation.

In contrast to much of the medical literature that describes menopause as a time of loss and decay (Fiske, 1993; Utian, 1980), menopause did not elicit expressions of great sorrow in this study. On the contrary, menopause brought these women a sense of freedom. More than one woman related her experiences of suffering over the years with menstruation. The relief and release that they describe is related to their meaning of menopause. Similar findings have been noted in current studies which found menopause to be a time of positive change in a woman's life to explore new interests and to create lives that reflect a woman's values and desires (Siegal & Doress-Worters, 1994). According to Cousins and Edwards (2002), women today are heavily influenced as to what they perceive as 'normal' and:

... are likely to interpret and blame many of their day-to-day health concerns (from headaches to depressive feelings) on low levels of hormones. Thus just the idea of failing ovaries can make women feel ill. (p. 332)

4.6. Summary

The majority of women in this study perceived menopause to be a normal life passage and an inevitable part of the ageing process. In their view, menopause represents the end of menstruation and the end of women's reproductive function which is not viewed as negative. Similar research today illustrates that contrary to popular belief, menopause can signify wellness and a normal life process in a woman's life (Coney, 1994; Greer, 1991). Given that menopause is linked to biomedical descriptions, some women have been influenced to expect difficulties at menopause and are surprised and concerned if they do not experience any difficulties (Cousins & Edwards, 2002). As the women in this study indicated, sometimes it is best not to know what to expect. Essentially, the women's social perceptions of menopause seem to be as diverse as those of women now. The difference, as reflected in the data is that the women in this study (with one exception) are *less* focused on searching for a remedy or 'cure'.

In this chapter I described older women's experiences of achieving-recognizing menopause by way of four themes: meaning; knowing-confirming; worry-anxiety; relief-release. In the next chapter, I will present the second theme: connecting-engaging with menopause. I will

explore the women's narratives under four themes: adaptation-adjustment; support-counsel; illness-malaise; options-power to choose.

CHAPTER FIVE: Connecting-engaging with menopause

In the previous chapter I presented the first theme of achieving-recognizing menopause based on older women's narratives from transcribed data. In this chapter, I will present the second theme in this study: connecting-engaging with menopause. I will explore this theme of older women's experience of menopause under four sub-themes: adaptation-adjustment; support-counsel; illness-malaise; and options-power to choose.

5.1. Adaptation-adjustment

As I have discussed previously, menopause has often been described as a life crisis when women become worried about their physical appearance, growing older, empty nest syndrome and loneliness (Defey, Storch, Cardozo, Diaz & Fernandez, 1996). Some studies suggest that some women grieve the loss of their previous life and become depressed about lost opportunities and anxious about their future (Darke, 1996; Quinn, 1991). Accordingly, every comment or action a woman makes is attributed to menopause and/or her inability to cope with menopausal symptoms (Gannon, 1998; Greer, 1991). This myth perpetuates the negative stereotype of menopausal women as dejected, wrinkled, overweight and frigid (Beasley, 1999; Carlson, Li & Holm, 1997; Fauconnier, Ringa, Delanoe, Folissard, & Breart, 2000).

Menopause not only reflects the possibility of old age, but it specifically focuses on the stigma of the ageing female. Gannon and Ekstrom (1993) examined what influences these images have had on attitudes toward menopause. They found that negative images that relate the psychosocial and physiological characteristics of menopause have the greatest influence on women's and men's attitudes. They argue that although menopause is recognized as a life stage, negative images portray menopause as an inescapable process of physical and social decline. Similarly Worcester and Whatley (1992) argue, that the biomedical model has taken advantage of women's fear of ageing in order to market a

hormone product as having the potential for improving the quality of life for menopausal women. Women are seen as being vulnerable and unstable and this image disseminates the belief that woman's weakness stems from her reproductive function.

In addition to difficulties with body image, Fodor and Franks (1990) draw attention to the many adjustments that today's mid-life women face in comparison to previous generations of women. According to the authors, mid-life women today are confronted with issues such as full time employment, single motherhood, second marriages, stepchildren, managing their own business and ageing parents in addition to managing menopausal symptoms. Were women confronted with the same issues twenty- five years ago?

The women in this study experienced a variety of life adjustments during menopause. Elizabeth made it clear that she was busy adjusting to a second marriage and "*... was too busy getting on with life*" (p. 2) to be concerned if her menopausal symptoms were upsetting her life. Catherine explained that menopause brought no changes to her life and "*it didn't make any difference to what I was doing.*" (p. 2) and accepted any symptoms she may have had to be a part of the ageing process.

As the oldest woman in this study, Ann encountered menopause approximately 35 years ago and even though she does not have precise recall of some details such as, the name of the 'nerve tablet' she was taking, Ann was able to remember some periods of irritability when she "*was easily upset*" (p. 2). Ann compared these periods of irritability as the same feelings she had experienced when her menstrual cycle had been due. Ann concluded that hormones have an effect on women throughout their life and questioned why any symptoms a woman may experience during menopause should be dissimilar to those experienced during puberty.

Mary made a similar comparison of menopause and menstruation. Mary's life was full of activity – she was a single mother, worked full time, managed her home and was the sole wage earner. Mary explains how she used to become quite irritable during the time when

she would expect her period. She equated her feelings of irritability that she experienced during menses to be similar to those she experienced during menopause:

... and when I had a period I was very sharp and I knew a couple of days before and everybody was so stupid then. (p. 2)

Mary's children had moved away from home and Mary was living on her own. Because of her situation, Mary found that she had no choice but to ignore the hot flushes and the irritability she felt and "had to just get up and go and start doing things." (p. 2).

Although the women in this study were challenged with similar issues such as single motherhood, full time employment and empty nest syndrome, they did not express any fears about ageing and accepted menopause as a transition into another stage in their lives.

Depression has also been linked with menopause, however depression appears to be more closely related to the psychosocial factors that women have to contend with rather than the physiological changes. George (2002) found that some women relate any physical and emotional changes to their hormonal status. She claims that women who experience depression during menopause are more than likely have had a history of pre-existing situations of depression prior to menopause, such as pre-menstrual tension and post partum depression.

Joan had suffered from heavy bleeding, which resulted in a hysterectomy. Although she states she went through menopause much later after her hysterectomy, she describes the time after the hysterectomy, as the occasion where she had to make a change in her life. She talks about this period in her life when she became a recluse and:

Very unsociable. ... I wasn't a bit sociable at all. No, I didn't want to go anywhere, I was very unsociable. So unsociable that my doctor said, for heaven's sake, let's get you back to work. So I went back to work ... (p.2)

The negative image of a menopausal woman as frigid and depressed about ageing has been disputed by several authors (Coney, 1994; Friedan, 1993; Greer, 1991; Phillips & Rakusen, 1996). Sheehy (1998) points out that women who enjoyed a healthy sex life before menopause, are more than likely to go on enjoying sex after menopause. In fact, she points

out, that some women become more sexual as they no longer have to bear the burden of birth control. Lack of interest in sexual activities was not evidenced by most of the women in this study. Victoria and Judith were the only two women that discussed some aspects of their sexual activities.

Victoria explains that her first husband had left her and she was a single mother with three children to care for. Nonetheless, Victoria met another man a long time after her husband left and they started a relationship. As she had been prescribed the birth control pill for her heavy bleeding, the relationship moved to the next level and she enjoyed a healthy sex life. When she made the decision to stop taking the pills, she was concerned that she may need another form of contraception. Instead Victoria found that menopause gave her a new lease in life.

... when the menopause comes I won't have to have any more worries, you don't have to take any precautions. (p. 3)

Occasionally some adjustments in life had to be made due to circumstances rather than due to menopause and depression. Judith lived on a large farm where her major responsibilities were cooking and maintaining the home. Judith maintains that although she experienced no physical symptoms during menopause she felt that her relationship with her husband changed.

... we had a good friendship relationship, the sexual part of it may be faded a bit but we were still good friends. (p. 2)

However, Judith does not hold menopause entirely responsible for this change. She clarifies that her husband was a war veteran, as a consequence suffered from bad health which she believes aged him and he developed hip problems that interfered with his farm work and their relationship.

However one participant did address the deep distress she experienced while attempting to adjust her life during menopause. Agnes's feelings of loss and grief appear to stem from a sense of loss of one's former self and the absolute end of this period in her life. Agnes reflects on the time when she came to the realization that a hysterectomy would remove any chance for more children:

I did get moody about it, but I was so angry with myself or angry with the whole lot. I did not want to talk about it. I gave my husband a bit of a hard time. (p. 2)

In a study of 61 peri-menopausal women by Kittell, Mansfield and Voda (1998), women's responses indicated that perceived changes in menopause such as, unpredictable heavy periods, hot flushes and mood swings did cause some disruption in the women's lives. The study found that women's acceptance of these changes in their lives during menopause was directly associated with whether or not women allow their hormones 'to rule' their lives. In addition they argued that any disruption the women may have experienced was directly related to whether or not the women associated these changes with menopause and ageing.

In sum, some studies have shown that the physiological and psychosocial aspects of menopause such as change in marital relationships and/or role change may affect some women's experiences of menopause (Spitzer, 1995; Stephens, 2001). It is well documented that for some women life changes may cause stress and necessitate some adjustments that may be accompanied by symptoms commonly associated with menopause (Moen, Dempster-McClain & Williams, 1992; Quinn, 1991). However in this study, although the majority of the women did experience adjustments during menopause, they did not dwell on their symptoms or blame the changes on menopause – they adapted and moved on with their lives.

5.2. Support-counsel

How a woman feels or sees herself is only one part of whether or not she will experience a positive or negative attitude to her experience of menopause. Cross cultural studies indicate that in those cultures where there is improved status at middle age and a clear role for the mid-life woman, there are greater feelings of well being in the menopausal years (Lock & Kaufert, 2001).

In discussing menopause and mid-life changes with the woman in this study, I found that far from seeing their lives as being over, the majority of the women tended to feel they were moving toward a new stage in their life. Menopause was recognized to be a developmental passage and this was acceptable to them. A driving factor for some of the women to be part of this study was their hope that other women would benefit from their experiences. Victoria explains her reasons for agreeing to be part of this study:

... somehow or other it just appealed to me because I had been nursing and maybe there was something I could say ... (p. 1)

Helen explained that she had an interest in medical matters and:

... this is just a life experience that I thought I could quite make useful to you. (p. 1)

Anderson's (1998) study on menopause included discourses on what effect a woman's relationship with her husband/partner may have had on the women's understanding and experience of menopause. The majority of the women in that study reported that although they felt they had their husband's support, they generally felt that their husbands did not entirely understand what the women were *actually* experiencing. Anderson (1998) found that although the husbands were better informed and able to discuss changes women may experience during menopause, the husbands' reactions to the *actual* changes exposed the common myth that all women's behaviour was related to their hormones. The women in this study described the support they believed they received or did not receive from their husbands or partners.

At first, Ann felt quite isolated as she "*didn't have a mother to speak to, nor sisters*" (p. 1), "*things were not explained*" (p. 4) and she relied on her husband for support. Throughout her life, Ann maintains her husband has been supportive and assisted her with the children and household tasks. However, when Ann was going through menopause:

I'd sometimes think my husband perhaps wasn't as caring as what he could have been, which might have been true and it might not have been. (p. 1)

Ann rationalized and excused her husband's attitude and lack of support and was somewhat forgiving to his attitude:

... I think it's hard for them to understand how you feel and what you go through. I mean they say men go through sort of menopause... but nothing like a woman has. (p. 3)

Elizabeth's husband was a doctor and he took control of the management of her menopause. Elizabeth described how her menopause "*was all just too easy*" (p. 3) and she felt quite confident in her husband's ability to support her both as a husband and as her physician. She explained that she was always able to talk openly and honestly about her menopause because she was able to relate her experience to the experiences that her doctor/husband described. It is interesting that Elizabeth did not perceive that her husband, as a medical practitioner had a conflict of interest in addition to the fact that she was classified in the same group as other women.

... if we were discussing a patient, I'd (say) I've been a bit like that too and we'd chat away. (Elizabeth, p. 2)

Helen reasoned the knowledge and information she gained through the radio and her reading supported her through her experience. In addition, her husband alleviated any concerns she had about her symptoms in a similar approach as the men in Anderson's (1998) study had.

... he made some allowances for when I used to get hot, he would understand. (Helen, p. 3)

Agnes experience of menopause was different to the other women in this study as she had surgically induced menopause when her ovaries were removed during a hysterectomy for an abnormal pap smear. Agnes indicates that she experienced menopause approximately 24 years ago and it was a topic that was not discussed much. She believed that the doctors at that time "*didn't like too many questions asked*" (p. 4) and she was not able to discuss this event with anyone and especially not with her husband.

My husband would say, what do you mean angry, why, what are you talking about – he would not understand anyhow – he was old fashioned. (Agnes, p. 5)

The lack of support that Agnes feels that she did not receive is still evident after all these years. Agnes's marked anger and pre-occupation with babies consumed her life. She denies having any feelings of depression (although she clearly admitted to feelings of isolation and

being withdrawn) and explains that she did not have anyone in whom she can confide, not her friends and not her twin sister.

Nobody you know. It's only a new thing, this talking about personal, like menopause, and all these things, it did not really happen in my generation.
(Agnes, p. 5)

Beasley's (1999) study indicated older women identified other women as an essential source of information on menopause. With the exception of Agnes and Judith, most of the women in this study identified other women as their source and support during menopause. As a nurse Joan had the opportunity to discuss and receive support from other women in the clinic.

I was working in a clinic with a lot of women and you know, you all bolster each other up because we were all about the same age. Because nurses are pretty good at talking amongst themselves really. It's about the only profession where you can. (Joan, p. 2)

Another nurse, Victoria shared similar reflections of the support she received when she shared her menopausal experience with other women her age. Victoria was able to offer what she believed to be, 'solid' advice to women today:

... hope you have an easy one. That's not advice, that's just hope. ... if you run into trouble you must go and get it sorted out ... (p. 4)

Victoria was unable to explain what she meant by 'trouble' and was not clear on how a woman should 'get it sorted out'. Her advice could have been influenced by the gynecological problems her daughter was experiencing at the time of the interview.

I don't think people have to put up with it. There must be something. Don't put up with problems. (Victoria, p. 4)

It is interesting to note that although Victoria did not feel that her own menopause required any medical support or advice, she without a doubt suggested that women should go to see a doctor so that 'something' that could be done to help women with menopausal symptoms. According to Victoria, women today appear to be suffering more physical discomforts than women in her day. She points out that doctors did not pay much attention to women's complaints as menopause was perceived to be a normal part of the ageing process and women were assured that any 'problems' they may experience, would disappear once

menopause was over. Once more, it is difficult to evaluate whether her daughter's problems influenced her present day view of menopause.

The other women in this study revealed similar narratives about the lack of interest by their doctors in discussing menopause. Mary describes her visit to the doctor:

... when I visited the doctor it was a case of you asking the question and I don't think he thought 'oh, this woman is in menopause ... he told me I could deal with that myself, ... and I suppose I thought I must know what it is. (p. 3)

Judith, who is a nurse, had no menopausal symptoms and never discussed menopause with her friends or her doctor. Judith's reasoning was practical and she frankly did not see any reason to consult her doctor about menopause.

The GP that I visited, I had no connection with anything in that nature at all. I'd always been with an obstetrician for the babies and the babies were over, all that was over so if I met him around it's still lovely, pleasant to speak with him, but I didn't consult him again after the babies were born. (p. 3)

In a comparative way, Doreen explained that she was satisfied with what information she received from her friends and from the nurses at the hospital where she volunteered, and that there was no need to consult a doctor. Doreen indicated that most doctors were not interested in listening to what women had to say or were quick to offer sleeping pills or tranquilizers to keep them silent. Menopause was not seen to be an illness, therefore there was no reason to seek treatment from a doctor.

I mean there really is no point in talking about it to anyone else, ... I cannot remember ever talking to him (her doctor) about it. After all, what is there to say, ... it's normal, so what is there to talk to him about. You know a person goes to a doctor if they are sick, so why would I talk to him about no more periods and all those things. (Doreen, p. 3)

Similar accounts by women today were reported to Phillips and Rakusen (1996), of instances when women felt doctors were not listening to them, did not believe what they had to say, talked down to them, withheld information, did not warn them of the risks or negative effects associated with hormonal therapy, and offered them moral advice instead of medical care or support.

Similarly in a study by Budge, Stephens and Carryer (2000), women expressed their frustration and uncertainty at not being accepted as able individuals capable of understanding and comprehending, when consulting their doctor on menopausal symptoms. Some women described how the paternalistic attitude by their doctors intimidated them into making hasty decisions about a course of treatment, while, other women expressed the confusion they felt when their doctors overloaded them with too much information and left them unable to make a decision.

When asked what advice the women thought they could offer today's women on menopause, Joan, Agnes and Helen recommended women should just 'get on with it'. As discussed in chapter four, Mary was the only woman in this study who attached a negative meaning to menopause. She did not seek any advice from her doctor about her symptoms and perceived menopause to be something that happens to all women in the normal course of their life. Even though Mary had experienced a relatively easy menopause, she recommended that women:

... should go seek medical help. At least talk about it and see whether the symptoms that they are feeling are expected and if there are any behavioural changes that you should expect in your life. (Mary, p. 3)

When asked about what support women today may require for their menopause, Doreen dismissed this as unnecessary explaining "*this happens to all women*", and emphasizing menopause should not prevent women from "*do all the things in life that are important*" (p. 4).

Judith reasoned that today's generation of women are experiencing multiple life changes and coping with more responsibilities in comparison to her generation. Judith concluded that because of these differences, she was unable to offer any advice about menopause to women today.

I feel that these girls now live a very different life from what either my mother or myself did. ... Whereas my daughters have had to work their entire married lives and I feel that is the big difference. So they've had to bring up children, run houses, run husbands and get on with their own affairs as well, their own health as well so I think they've got far more, but I think they are more vocal. I think they will go for advice or medical help if

they needed it, far more readily than perhaps my generation did. And of course, there are a lot of women GPs now and specialists which we didn't have. (Judith, p. 3)

In sum, the majority of women in this study believed that they had all the support that was available for them at that period of time. On the one hand, the women viewed menopause to be a normal passage in life and something that does not require much attention or support from family, friends or their doctors; on the other hand, the majority of the women were quick to recommend that today's woman should seek help for menopausal symptoms and support especially from medical practitioners. This surprising variation of menopause being accepted to be an illness for today's woman but not an illness 25 years ago, will be discussed further in the next sub-theme of 'illness-malaise'.

5.3. Illness-malaise

The notion of menopause as an illness has been supported by the medical model (Coney, 1994; Greer, 1991; Lupton, 1994). Contemporary medicine is based on historical truths – women's illnesses are thought to be psychogenic in origin and related to women's neurosis around their reproductive cycles (Ehrenreich & English, 1979; Jordonova, 1989). According to Asso (1983) the only indication that a woman may be in menopause is the abrupt end of menstruation. She points out that all the other hormonal, organic or bodily changes span a number of years and varies from one individual to another.

The average 'profile' of the menopausal women in medical discourses shows the following: a sense of regret and sorrow over lost capacities and opportunities (Cousins & Edwards, 2002; Gonyea, 1996), a fear of growing old and a loss of femininity (Friedan, 1993; Harding, 1996; Worcester & Whatley, 1992), or anxiety and depression (Ballinger, 1990; Warga, 1999). There are other lists of 'symptoms' that have appeared in the literature, all of which, creates a set of 'symptoms' which are often not relative or comparable.

The majority of women in this study did not perceive menopause to be an illness or disease and did not consult their physicians specifically about menopausal symptoms. Joan's problems with bleeding caused her to consult her physician. Once her condition was 'cured' with a hysterectomy, her doctor suggested she return to work and she had no further need to seek medical treatment. Once Catherine's doctor suggested her 'funny feelings' indicated she was in menopause, Catherine did not seek any further discussion or treatment of her 'funny feelings' with her physician.

Whilst Ann was prescribed "*nerve tablets to take*" (p. 1), she did not believe that any other physiological problems she may have experienced at that time, may have been related to menopause and her doctor supported this view. Ann's doctor continued to 'treat' her other medical problems but never considered menopause to be a medical problem requiring further treatment.

...well the doctor thought I had a bleeding ulcer because my blood was in such a bad way and I went and had all, you know the things they put down in your throat to look inside and they did all that. I had ulcers but they'd sort of healed over but otherwise there always seemed to be some small thing cropping up. (Ann, p. 4)

Mary believed that most doctors liked to feel they had power and control over their patients. Mary described how doctors pretended that their medical knowledge gave them the right to be seen as having 'all the answers'. After our taped interview, she explained how doctors like to do all the talking and do not give women the opportunity to ask questions in fear that they may not know the answers. According to Mary, most doctors did not encourage questions about menopause because they really knew nothing about menopause – the doctors knew that menopause was part of 'getting old' and had nothing to do with medicine. Mary clarified that women 'in her day' generally associated any problems they may have had, to be a part of the ageing process. Unless there were some apparent symptoms, such as bleeding or should a woman ask a specific question, physicians usually disregarded menopause, as it was not seen to be an illness.

I can ... remember at one time going back for some tests and he said that my thyroid was low which is something which happens in menopause and he said to me that you can help yourself very much better yourself than by

taking anything. Which I didn't pursue in question of him but I presumed I had to just get up and go and start doing things. (Mary, p. 1 – 2)

Interestingly, Mary's perception of menopause and illness is quite similar to Victoria's views on the lack of support and advice women received from their doctors for women in her day (see chapter 5.2). Did doctors not provide the support because menopause was not seen as an illness? Or, did women consider menopause not to be an illness and therefore, did not ask for support or advice?

In analyzing the collected data, it was clear that even though menopause was considered not to be a medical problem for these women, medical discourses did provide the language for most of the women in describing what menopause is. For example, three women spoke about menopause and hormones, which was surprising given the lack of medical explanation of menopause the women received from their doctors. How did their view change from menopause as a normal passage of the ageing process to menopause as a medical problem that no woman has to put up with?

Even though Helen did experience some night sweats and hot flushes, she felt there was no need to take any medication. Helen came to this decision on her own after she researched all the information that was available for her at the time, on HRT.

For one or two of my friends who had excessive bleeding and they did consult their GP. But most of them who had problems, just kept them to themselves, really, in those days. (p. 4)

Helen has never regretted her decision not to take HRT, but did express some concerns she has had recently, regarding osteoporosis. Helen feared that since there has been much focus and attention being made on the role of HRT as preventing osteoporosis, she has spent some time reflecting on whether she made the 'right' decision not to take HRT.

Elizabeth explains that her menopausal experience was not like the average woman, since she was married to a doctor. Elizabeth's doctor/husband regarded her menopause to be an illness and Elizabeth acknowledged this by following any treatment he prescribed.

... you know the medical reps come round and they ... oh you do this and you do that and I remember at one time I was taking half a dozen different pills but one of them was supposed to make your menopause very much easier. ... So I had a good try on all sorts of things. (Elizabeth, p. 2)

Doreen describes one scenario when during a hospital Christmas bake sale she began to have a hot flush and a doctor's wife happened to notice this.

I really did not know her that well, ... I was having a hot flush, ... and she asked me if I was going through menopause. I was shocked that she would ask me ... you know it is one thing to talk about it with a friend, but her ... I did not really know her. Well after I got over the shock, I said, yes, ... well, she said that I can go to a doctor and those flushes will disappear with some pills. (laughter) ... I told her thank you, really what can one say. (p. 2)

Agnes spoke about menopause as being “*perfectly normal*” (p. 4) and suggested that perhaps women today were actually creating problems for themselves because these problems would mask their behaviour at times. It has been suggested that menopause (as hysteria was in the past) being diagnosed as a disease, as defined by the medical profession, has enabled women to assume a sick role and has allowed them to renegotiate their role in the family (Broom, 1995; Conrad, 1992; Ehrenreich & English, 1979; Fisher, 1986; Riessman, 1989; Smith-Rosenberg, 1985). The restructuring of domestic activities to accommodate the illness essentially permitted a woman to opt out of her traditional role and a respite from her responsibilities. What is different for women today? Do women embrace the sick role as an escape from their responsibilities or as (Agnes and) Riessman (1989) suggest, the sick role may claim to exempt women from the responsibility for being sick. In other words, the responsibility for staying well is solely placed on women and should they not to be able to maintain their ‘wellness’, other options or persons may need to do this for them (Loppie and Keddy, 2002).

This consciousness has been intentionally constructed in a very individualistic, ‘take care of yourself’ (don’t expect society, the government or the health system to take care of you) and victim-blaming way.

(Worcester & Whatley, 1992, p. 2)

Conrad (1992) argues that behaviour that is defined as an illness or is the result of an illness, absolves an individual of the responsibility of that behaviour. Further Conrad

(1992) argues, this exemption implies the necessity of placing an individual in the hands of legitimized 'experts' in order to get well. Think for a moment of the differences in consequence if a woman's inability to stay healthy is attributed to not taking HRT and risking heart disease or osteoporosis, or taking HRT and accepting a monitoring regime to ensure well-being.

In sum, menopause like any other physiological process is an intricate relationship between a variety of factors that are biological and psychosocial. The majority of women in this study did not see themselves as being 'ill' even though they may have endured symptoms that can be related to menopause. One cannot help but be skeptical about the way medicine embraced menopause as a disease by using biological definitions and women's fear of ageing, and at the same time suppressed any social meanings and/or women's own experiences that may have contributed to an understanding of menopause.

The medical profession has the power to legitimize illness, to make decisions about medical procedures and to recommend treatment (Conrad, 1992; Riessman, 1989). Then again, the economic, social, and political factors that constitute the very factors of society are reflected in the health care system where "... both physicians and women have contributed to the redefining of women's experience into medical categories" (Riessman, 1989, p. 191). Is there a fundamental division between women and their experiences of menopause, on the one hand, and medicine's interpretation of menopause as a disease, on the other hand? In defining menopause as an illness, does this allow women to interpret, communicate or cope with the symptoms associated with menopause?

5.4. Options-power to choose

Over the last 20 years, medicine has altered its approach to menopause and now views it as a hormone deficiency disorder rather than, as previously assumed to be merely a 'state of mind' (Utian, 1980). Phillips and Rakusen (1996) argue that over the last 50 years the medical ethos has penetrated into the framework of women's lives so subtly that women

were not even aware of its influence. Women are increasingly encouraged to take part in making decisions about HRT. By giving women more information and options, are women today able to make informed decisions about the management of their menopause? How and what choices did women in the past base their decisions on the management of their menopause?

Joan, Victoria and Catherine did not believe they had any options regarding the management of their menopause. They believed they did not need their menopause to be managed and accepted this event to be a passage in their lives. According to Stephens (2001) some women today claim that maintaining a positive attitude and keeping themselves busy facilitates an easier passage through menopause.

Even though Doreen suffered from hot flushes and at times was somewhat embarrassed by her hot flushes when in public, she was not convinced that her menopause required to be managed in a different way. Doreen's attitude was similar to the mind-set of women in a study by Davis (1992) about menopause in a Newfoundland fishing village, where the expectation among all the women was that menopause was a hardship to be endured and 'suffered in silence'. The women's lives and the village were interconnected in the social organization of life in a single occupation community. All the men fished and the women were hardworking and stoic. Menopause was the least of the women's problems and something women accepted to be part of their life to endure.

Elizabeth was not given any choice regarding the management of her menopausal symptoms as her husband was looking after her and she had blind faith in his ability to 'care' for her. Mary presumed any options she may have had regarding her menopause was a matter of opportunity as in the "*case of you asking the questions*" (p. 2) when one visited the doctor. As Mary pointed out, how can one ask questions about something that happened to all women as part of their the normal ageing process.

Similarly, Helen supposed if her experience would have been different and problematic, she would have made it her business to find out what choices were available to her.

I believe I would have had if it had got to a stage where I wanted it managed, yes, ... but at the stages I went through it didn't occur to me that it needed managing. (p. 3)

Agnes was the only woman in this study to express some reservation on the way her menopause was managed. When her doctor made the decision that a hysterectomy was necessary, Agnes felt powerless as she was not given the option of retaining her ovaries.

And so they decided to a hysterectomy, which they did. Now what he did which was quite new in those days, don't forget this was 22 years ago, no 24 years ago, he took out the ovaries and he gave me implants, hormone implants. They would last for two years. (p. 1 – 2)

When I pressed for more information or specifics about the 'hormonal implants' Agnes was unable to provide any more details, pinpointing the lack of information that she received at that time.

he didn't explain anything. He just told me afterwards that it was what he had done. He said it will help you, it will stop the hot flushes and that type of thing or whatever you get . (p. 2)

According to Judith, women in her time were disadvantaged since they did not have the same option as women today have. Judith believes that women today have far more choices regarding the treatment of their menopause including the option of seeing a female doctor. Judith explained that women are more comfortable discussing personal matters such as menopausal symptoms with a female doctor.

... a lot of women GPs now and specialists which we didn't have. A lot (of women) would feel happier speaking with a woman than a man. (p. 3)

The majority of women in a study by Turia (1998) expressed similar accounts of a preference for female doctors rationalizing that female doctors were more than likely than male doctors to have a better understanding of women's personal and intimate matters such as, heavy bleeding than male doctors. In addition, the women in that study felt that women would receive more guidance and support from female doctors regarding their choice to take HRT. These findings are interesting to note as Friedan (1993) points out, female doctors are subjected to considerable pressure from the medical establishment to encourage women to use HRT, and as a consequence may overlook to explain some of the serious side effects that women may experience.

A growing number of options are available to women today for the treatment of menopausal symptoms such as hot flushes or long term health risks such as cardiovascular disease or osteoporosis (Cutson & Meuleuman, 2000). From 1993 to 1999 the rate of HRT prescriptions in New Zealand doubled, thus indicating that 25 per cent of women aged 45 to 60 years are assumed to be on HRT (Stephens, Carryer, & Budge, 2001). According to Coney (1994), women's choices about HRT are largely founded on commercial interest and controlled by men that regard menopause as a commodity and exploit women for commercial gain. Oddens, Boulet, Lehert and Visser (1992) found that HRT use was greater in women who consulted a physician for menopausal symptoms during the 12 months preceding their study. Of the 22 per cent of women who consulted a physician, 11 per cent of women aged 40 years and over used HRT and 18 per cent used tranquilizers. There is little data available on the use of any sedatives, anti-depressants or other remedies, being used by New Zealand women today (Beasley, 1999) to accurately indicate what options or treatments that women are using to manage their menopause.

In sum, the majority of the women in this study did not believe they had any options regarding the management of their menopause. Menopause was perceived, both by the women and their doctors, as a passage in life and something one had to 'put up with'. With the exception of Elizabeth and Agnes, who were 'supervised' either directly or indirectly by their physicians, the women were not offered any other choices or options, including using hormonal therapy. However, this can be explained by the fact that in the 1970s, doctors were reluctant to prescribe ERT (Estrogen Replacement Therapy) to women because of the reports linking oestrogen with increased rates of endometrial cancer in women at that time. Ann rationalized that although women today appear to have more choices and options than women in the past, it seems that women today are suffering far more symptoms related to menopause than women in her generation.

I did it my way in our day and today they might have added advantages that perhaps we didn't have, but I don't think they're better off than me, at all.
(Ann, p. 4)

5.5. Summary

The women in this study accepted menopause to be a passage in their life and generally accepted any problems they may have experienced were more than likely to be associated with biological changes related to ageing. They described the changes they experienced in adjusting to this 'normal' passage in life and what support they had received. The women described the little interest paid by their physicians and lack of support they received from them regarding their menopausal experience.

Phillips and Rakusen (1996) suggest that the majority of women do not question the biomedical definition of menopause as a deficiency disease and willingly accept the role medicine has occupied in the course of women's normal life experiences. The women in this study did not view their experience of menopause as an illness, yet they were willing to accept and condone the role that medicine can occupy in women's experiences of menopause today.

In this chapter, I described women's experiences of connecting-engaging with menopause under four sub-themes: adaptation-adjustment; support-counsel; illness-malaise; and options-power to choose. In the next chapter I will conclude this thesis with a summary of the findings and discussion on what if any relevance this study may have on nursing knowledge.

CHAPTER SIX: Discussion and conclusions

The previous two chapters explored the findings in this study. A descriptive analysis was presented under two themes: achieving-recognizing menopause and connecting-engaging with menopause. This chapter will bring this thesis to a close by reviewing the aim of this study, the findings from the women's stories, and discuss the implications for nursing practice and any limitations of this study.

6.1. Review of the aim of this research

The aim of this study was to capture retrospectively older women's experiences of menopause prior to it being defined to be a deficiency syndrome. This qualitative descriptive study underpinned by feminist epistemology explored ten older women's experiences of menopause before menopause came to be perceived as a problem requiring medical treatment. The specific research question was: what experiences of menopause did women have 25 to 30 years ago?

The focus of this study on women's experiences of menopause supported a feminist analysis as it documented the activities of a group of women; endeavored to value the experiences of women from their own point of view; and, it conceptualized women's activities as faithful to the worldview and lived experiences of some women (Reinharz, 1992).

6.2. Findings

Several sub-themes such as, meaning; knowing-confirming; worry-anxiety; relief-release; adaptation-adjustment; support-counsel; illness-malaise; and options-power to choose

emerged from the evaluation of the data collected in this study. These sub-themes focused on the women's descriptions of their experiences of menopause. These sub-themes supported two central over-riding themes: achieving-recognizing menopause and connecting-engaging with menopause.

The findings in this study were analyzed with particular attention focused on the women's positive attitude regarding their menopausal experiences. These feelings could possibly be explained by the length of time that has passed since menopause, causing negative experiences to be either downplayed, forgotten or accepted by the women. Nevertheless, most of the women did clearly describe the symptoms from which they suffered and the impact these had in their private and public lives.

6.2.1. Theme One: Achieving-recognizing menopause

During the data collection phase, it became increasingly apparent that the women perceived menopause to be a 'natural' and 'normal' life developmental stage. There was consensus that menopause was a non-event and something to be dismissed or ignored. The women accepted menopause as a 'normal' process with an understanding that their bodies were progressing in a developmental life phase of which they had no control. The women understood their physical experiences and bodily changes to be part of this 'normal' process of change.

In contrast a study by Stephens (2001), described how some women today "... spoke of returning to 'normal'." (p. 657). The women in that study described the effect menopausal symptoms claimed on their physical bodies to the point that the women disassociated their physical experiences away from their 'self' toward their 'inner body' pending the return of their 'normal' self. The difference between that study and this one is apparent, given the meaning that each group of women has assigned to menopause: menopause is 'normal', menopause is not 'normal'. Could the difference be based on what information is available to women? Women in the past received little information and relied on friends as their

source of information. Today's women draw their information largely from the mass media and medical practitioners (Anderson, 1998; Clinkingbeard, Minton, Davis, & McDermott, 1999; Turia, 1998; Stephens, Carryer, & Budge, 2001). Could the difference be explained by the excessive information and promotion of HRT with which women and general practitioners are now inundated? Interestingly the two women in this study who had their menopause verified by a physician were the only women who were medicated for their symptoms.

Generally the women in this study who did experience some physical discomfort during menopause accepted these symptoms as 'normal' with the knowledge that in time, the symptoms would pass. In contrast Anderson (1998) writes, how some women today have become watchful for particular symptoms and worry about each bodily change, and become especially vigilant on whether what they are experiencing is 'normal'. Can the difference be explained by the fact that today's women are exposed to phrases from biomedical discourses, such as, symptoms, benefit and risk, hormone levels and language such as mood swing, loss, grief (Cousins & Edwards, 2002; Stephens, Budge, & Carryer, 2002)? Is it possible that women today *expect* to have problems at menopause (Cousins & Edwards, 2002)? Cousins and Edwards (2002) explain:

Because menopause is linked to social and medical descriptions, such as "in that time of life" and "hormonal deprivation", midlife women are vulnerable for medical intervention whether they feel unwell or not. (p. 326)

Although all the women in this study mentioned several meanings of menopause consistent with those identified in other studies of today's women (Andrews, 1998; Beasley, 1999; Forster, 1994, Stephens, 2001), principle among all the studies was that menopause represented freedom from fear and worry about pregnancy. Overall, the women in all studies reported that menopause meant freedom from fear and worry about pregnancy. However, two participants described the paradoxical circumstances that menopause places women in: the inability to bear children can also represent the loss of femininity. Greer (1991) explains:

At menopause as never before, a woman comes face-to-face with her own mortality. A part of her is dying. If she has been encouraged all her life to think of her reproductive faculty as her most important contribution, the

death of her ovaries will afflict her deeply. Nothing she can do will bring her ovaries back to life. The grief of menopause affects every woman consciously or otherwise. (p. 124)

There is little doubt that with the approach of menopause, women are confronted with the need to reassess who they are and what they are doing with their lives. Feelings of loss and grief appear to stem from the fear of change and sense of loss of one's former self. With menopause, life is hardly about to end. However, many women in Western society experience an intense awareness the limited time ahead (Cousins & Edwards, 2002; Lee & Choi, 2002). Women in this study were more circumscribed than women are today, as women in the past learned to identify their roles and responsibilities primarily with the home and childrearing (Greer, 1991; Morgan, 1998; Quinn, 1991; Spitzer, 1995). Can the difference be explained by the different perceptions by women of the bodily changes associated with menopause and the recognition of these changes as part of ageing?

Negative life changes have a greater impact on one's health perception than positive life changes. The women in this study maintained that a positive attitude was synonymous with staying healthy. Successful ageing can be depicted as living both healthy and active lives. The participants in this study consisted of women who were wives and mothers in the 1960s and thus were socially integrated to some degree by virtue of their roles. All the women in this study considered menopause as a marker for ageing. Is there a difference between the view adopted by women in this study to the view assumed by today's woman?

Menopause brings about physical changes, which are understood and experienced in the context of women and biology. These biological events interact with the sociocultural events in women's lives (Broom, 1995; Browne, 1998). These interactions change and are given different meanings at different points in women's lives. In other words, women's biology and her experience of it, do not exist in a social and political vacuum, but in a society which is interlinked with social divisions. The women in this study expressed the relief they felt knowing that the years of painful menses and childbearing were over once they reached menopause. Beasley's (1999) study also found some evidence that women today conveyed freedom and release from menstruation and fear of pregnancy.

For the majority of women in this study, the close of the reproductive period of their lives in no way automatically determined their declining status, prestige or power in society. They believed that they were progressing to the next natural and normal stage and were accepting of this. They understood that in achieving menopause, they were being offered the freedom to embark on other experiences of life and recognized that menopause was a normal stage in the process of ageing.

For women today, menopause often represents a collection of negative facts about women's bodies, women's nature, entities often seen as requiring medical surveillance and management (Cousins & Edwards, 2002; Greer, 1991). This attitude to the female body is not novel, as a similar process can be seen in medical discourses on obesity (Carrier, 1997). Women's problems during menopause are characterized by signs and symptoms considered appropriate and supported by a medical discourse. Medical discourses implicitly pre-suppose the language of menopause to a disease model explanation (Cousins & Edwards, 2002). Mid-life women today are not made to recognize that they are moving to a new stage but to a status that is lower than that of younger women, hence it is hardly surprising that women would resist the physical changes associated with menopause (Greer, 1991; Kittell, Mansfield & Voda, 1998).

She can at last transcend the body that was what other people principally valued for her, and be set free both from their expectations and her own capitulation to them. It is quite impossible to explain to younger women that this new invisibility, like calm and indifference, is a desirable condition.
(Greer, 1991, p. 378)

6.2.2. Theme two: Connecting-engaging with menopause

Once the women in this study recognized that the changes they were experiencing were the normal changes associated with menopause, they made the decision to adapt these changes into their everyday lives. The women in this study expressed a variety of life adjustments they underwent during menopause from single motherhood, divorce, second marriages, and family illness. Some of the women were involved in new relationships and experienced a new sexual freedom; others adjusted to a life of companionship. The majority of women

believed hot flushes were something to be endured. Three of the women described periods of irritability however; these were quickly dismissed as being manageable. The women in this study did not spend their days focused on whether or not to take HRT. They spent their days on grappling with the changes in their families, retirement, new health problems and new lifestyle.

Even though the majority of the women in this study maintained that they had all the support during menopause that they needed, most identified that this support came from their friends rather than from their medical practitioners. One participant was prescribed 'nerve pills' and another followed medical advice and took 'some pills' that were supposed to help alleviate menopausal symptoms. Both women did stop taking the pills when it was apparent that they did nothing to alleviate symptoms! The physical changes associated with menopause were accepted both by the women and their physicians as 'normal' and the women just 'got on with it'. Interestingly, though the women did accept menopause as normal and not to be an illness, the majority of them were quick to refer today's woman to consult their doctor for help suggesting that their thinking has evolved in keeping with the social context they now occupy.

Some women today believe that physicians have all the information and knowledge, therefore the physicians should be the ones making the 'medical' decisions about their menopausal symptoms (Gonyea, 1996; Turia, 1998). In western society, the dominant 'health' model is the biomedical model and this provides the theoretical foundation for medicine's interpretation of an individual's illness experience (Conrad, 1992; Loppie & Keddy, 2002; Worcester & Whatley, 1992). The women in this study did not believe that their physicians had all the information and knowledge about what the women were experiencing. In fact, the majority of the medical practitioners dismissed the women's concerns and encouraged women to 'get on with it'.

Some women today do not feel they have all the information necessary to make informed decisions or feel that they cannot trust the recommendations their doctors make. Women wishing to make informed choices about HRT remain confused by much of the

contradictory information between their physicians, popular media and the 'scientific' information that is available to them (Anderson, 1998; Budge, Stephens, & Carryer, 2000; Hunter O'Dea, & Britten, 1997) Recent studies found that some women are looking for alternative treatments for menopausal symptoms (Morelli & Naquin, 2002) and are more informed about the current negative information about HRT are asking their doctors questions and are reviewing their options (Lewin, Sinclair, & Bond, 2003; Rymer, Wilson, & Ballard, 2003).

The medical model of menopause is confusing and contradictory at times as it clearly locates the source of women's problems within the individual, postulating a physiological condition that is assumed to require medical intervention however in turn, the medical treatment may create other problems for women (Conrad, 1992). It is a popular assumption that every woman runs a high chance of experiencing negative symptoms during menopause (Anderson, 1998; Beasley, 1999; Cousins & Edwards, 2002). The medical model usually mandates intervention by medical personnel with medical means as treatment for the 'illness'. How can women evaluate whether the recommended treatment is really in their best interest?

Cousins and Edwards (2002) argue that not only does the medical model inappropriately make some healthy women into patients, it compounds the problem by creating the possibility for them to be non-compliant if they do not follow medical advice. For example, is a woman who does not take the HRT prescribed for her a non-compliant patient, or a woman who has taken charge of her own life?

Belenky, Clinchy, Goldberger and Tarule (1997) draw attention to how women's connected knowing presents a personalized and particular version of reality, which connects thoughts and feelings through discourses in which women connect to other women and share their experiences. The meaning formulated by each woman is not stagnant – it will change over time as more knowledge is acquired or as actual experiences are realized. The knowledge each woman makes is a step toward a fuller and more accurate picture of herself – the picture becomes more clear and more delineated.

While western society has become more open in regard to what is considered acceptable behaviour, it appears women still cannot escape either the biological basis or particular traditions and attitudes that have survived. Mid-life women cannot escape the historical experiences of their own generation, although somewhat slightly different from preceding generations and the generations to follow. Women are expected to take responsibility for their later health, to change behaviour, to do everything to avoid what they are considered to be at risk of (Loppie & Keddy, 2002). This implies that a woman needs to do something to ward off her 'problems' and sets the stage for social control and victim blaming (Jordanova, 1989; Lupton, 1994). Thus, the shift moves from the focus of concern from the 'illness' to the individual's failure to follow advice (Kaufert & Lock, 1997; Lupton, 1994).

Medical practitioners have been trained to perceive objective reality according to a specific set of medical theories; if a woman's subjective experience does not readily fit into this perception of objective reality, then the experience must be discounted (Smith, 1998). Within medical discourses, women have no way of establishing their own experience as real. Women centred content, in which women's knowledge and experience is the central theme is recommended in order to correct the fact that women have been excluded from the knowledge base in most areas of study (Smith, 1998).

Context is an all-important feature in this study and for the readers of this study. No matter how we may attempt to escape the confines of our personal or historical locations, we shall always reveal the preoccupations and anxieties of our deliberations and disagreements in the time we live in. I presume no grand narrative from this study but it does seem to me that women's experiences of menopause are largely located within historical conditions, opportunities and constraints. A woman's perception of her menopause experience is largely based on her perception of the physical, social and psychological changes she undergoes (Sybylla, 1997). The issues and experiences addressed by the women in this study are different from those raised by women today, or are they?

Medical discourses on menopause are embedded in social, political and economical contexts. The women in this study were caught in a double bind – they had limited abilities

and access to medical knowledge and limited opportunity to question medical procedures or judgments. Women today are also caught in a double bind – they are intimidated by the ‘experts’ and influenced by popular media into making hasty decisions about the treatment of their menopause or they are given either too much information or contradictory information to make a decision on the management of their menopause.

6.3. Relevance to nursing knowledge

According to Meleis (1997), there are four characteristics that define nursing: nursing is a human science; nursing is a practice-oriented discipline, nursing is a caring discipline; and, nursing is a health-oriented discipline. As Meleis (1997) explains, the essence of nursing knowledge encompasses views and values based on “core understanding of experiences as lived” (p. 94) by an individual; that the primary mission of nursing is to “seek knowledge of human beings’ responses to health and illness” (p. 95); that nursing is holistic and has the ability to “establish connections” (p.97) and that “nurses uncover health strengths” (p.99) to empower individuals with self care behaviour that leads to their health and well being.

Nursing practice is directed toward bringing about positive change in an individual’s health status. Healthcare is a hegemonic structure where ideas, values and beliefs of a dominant group is embedded in the design of health institutions and in the consciousness of those who work in them (Carryer, 1997; DeMarco, Campbell & Wuerst, 1993). According to Huntington (1996), the values that dominate health systems are so powerful and enveloping that, “... it is a struggle for nurses to remain aligned to the person rather than the institution” (p. 170). It is notable that nurses were not identified as having a part in giving information or support both in this study and other recent studies (Anderson, 1998; Beasley, 1999; Berger & Forster, 2001; Turia, 1998). This was verified on a personal level, when I discussed my thesis topic with my colleagues and it became apparent that their knowledge was both medically embedded and based on myths.

The biomedical representation of menopause is dominant in the sense of being the most valued and most authoritative model by the majority of nurses and women. Sigsworth (1995) argues “... that the medical model’s dominance over nursing practice has also spilled over into women’s lives,” (p. 897). On occasion when I had the opportunity, I shared the topic of my research study with some of my colleagues. I was both taken aback and mystified at the responses I received, where the majority of suggestions endorsed the biomedical view of menopause. The majority supported HRT as the treatment of choice for menopausal symptoms. Although I explained that I was experiencing mild symptoms, their immediate response was that I had to accept that I was ageing and that I should not have to endure the possibility of worst symptoms. Some of the nurses did suggest alternative therapies, but usually as an affix to hormonal therapy.

Nurses can learn to see the lives and experiences of women realistically and holistically if they are to function effectively as advocates for women’s health. Nurse should examine their own attitude toward ageing and consider whether stereotypical perceptions of women’s nature and actions (Wright, 1998) bear any impact on their perception of women and menopause.

Nurses need to accept responsibility for imparting factual information and offering non-judgmental support to women passing through a phase in their life that may be confusing to them. Nurses should encourage women to discuss their experiences thus validating women’s experiences as normal and acknowledge that they are not alone in what they are experiencing (Hall and Stevens, 1991). To be responsive implies seeing others in their own terms and being open to the different ways in which others make sense of their own experiences.

Cultural and social norms at a particular time define ways of behaving, feeling and thinking as appropriate for women (Jackson, 1998). Women’s health involves their emotional, social, and physical well-being and is determined by the social, political and economical context of their lives and their relationship with others (Lippman, 1998). Nurses need to understand that women are situated within a social context comprised of personal

experiences from which meanings of their bodies and health are derived from. Women's health is about empowering women and giving them information (Kaufert and Lock, 1997). By labeling menopause simply as a disease (with its commercial potential and social control), disempowers women's personal experiences. Nurses can assist by validating women's experiences of menopause with an awareness of how women's health and illness is influenced by physical, psychological, and social factors at an individual level (social, cultural, economical) and at a group level (environment, economy, power, inequality) (McDowell & Pringle, 1992; Thomas, 1997). Women's self determination will drive women's responsibility over their bodies as their basic right, the right to determine the meaning of health and well-being.

6.4. Limitations of the research

This study suffered from several limitations. First, the principle weakness was the small number of women that volunteered to contribute to this study. As well as the small number, the ethnicity of the participants limited the variety of the data. The ten women in this study were all Caucasian middle-class women, and four had a background as nurses. No Maori or Pacific Island women volunteered or participated in this study.

The number of participants imposed some limitations on the study's content. Because personal information was sought, the women's participation had to be voluntary and their anonymity assured. The emphasis in this study was on the women's own experiences and understanding of menopause within the context of their lives.

Another limitation in this study was, the assumption that all would be admitted or revealed. The potential problems of recall may have reduced the reliability of some of the data. However, the semi-structured questions aimed to elicit attitudes and feelings as accurately as possible and in familiar terms.

Finally, I acknowledge that this analysis is by no means the single reality of all older women's experience of menopause. Although the experiences of these women is not enough to qualify their narratives as representative for all older women or all women in general, this study has given a new visibility to some women's actual experiences and offers the possibility of new research that can expand the boundaries of menopausal discourses.

Future research on menopause should focus on menopause as it relates to the physiological and psychosocial well-being of mid-life women thus bringing research more in line with mid-life women's interests as they would define them.

6.5. Concluding statement

When a major study in the U.S. on HRT was recently stopped, it made big news (Colville, 2002; Hill, 2002). Some of the findings of the Women's Health Initiative (WHI) trial involving 16,000 women taking the combined use of oestrogen/progesterone HRT, is not new. The trial was stopped early after a small increase of breast cancer (Li, Malone, Porter, Weiss, Tang, Cushing-Haugen, & Daling, 2003; and thrombo-embolic disorders confirmed suspicions raised in earlier studies (Chlebowski, Hendrix, Langer, Stefanik, Gass, Lane, Rodabough, Gilligan, Cyr, Thomson, Khandekar, Petrovitch, & McTeernan, 2003; National Advisory Committee on Core Health and Disability Support Services, 1993; New Zealand Guidelines Group, 2001; White, 2002). The WHI study has clarified and quantified these risks. The study has also identified an increased risk of stroke and heart disease (Hulley, Grady, Bush, Furberg, Herrington, Riggs, & Vittinghoff, 1998; Manson, Hsia, Johnson, Roussouw, Assaf, Lasser, Trevisan, Black, Heckbert, Detrano, Strickland, Wong, Crouse, Stein, & Cushman, 2003; Nash, Magden, Lustberg, Sherwin, Rubin, Kaufmann, & Silbergeld, 2003) and a much smaller benefit for fractures associated with osteoporosis (Ahlborg, Johnell, Turner, Rannevit, & Karlsson, 2003; Greenspan, Resnick, & Parker, 2003) than previously thought.

Growing old is a universal trait that begins with birth. Ageing represents a continuous interaction with the social environment as people change and modify their lives along this course. Women of all age groups live within a social and cultural context from which the meanings about their bodies and health are derived.

This thesis introduced some older women's narratives of their lived experiences of menopause and endeavored to challenge nurses to collectively examine the central role social and historical practices can play in shaping and producing women's experiences of their health. Constructions of women's health have changed throughout history but with the hegemony of science and medicine, women's experiences have been primarily determined by a dominant biomedical perspective (Carryer, 1997). This perspective has resulted in a master medical narrative of women's experiences of menopause thus, reducing their experience as only biological in nature.

Given the emphasis placed on the biomedical discourses on menopause, it is not surprising that there exists a strong push for menopause to be accepted as a disease requiring treatment. However, the authority of experience can empower women to discover alternative narratives. This study is one example of how research can reflect the multifaceted nature of women's experiences of menopause and validates women's experiences and understanding of menopause and health. The women in this study acknowledged menopause to be a time of change and opportunity and a normal process in their lives.

'Who are *you*?' said the Caterpillar.

This was not an encouraging opening for a conversation. Alice replied, rather shyly, 'I – I hardly know, sir, just at present – at least I know who I *was* when I got up this morning, but I think I must have changed several times since then.'

(Carroll, 1994, p. 43-44)

APPENDIX A

RESEARCH INTO WOMEN'S EXPERIENCE

OF MENOPAUSE

Advertisement / Flyer



“THE CHANGE”

Are you a woman aged 75 years or over?

**If you are interested in taking part in a study of menopause
and in sharing your experiences through a
private interview with a registered nurse,**

**please contact Teresa by phoning
528-9096 or 021-216-2310**

*This study has received ethical approval from Massey University Human
Ethics Committee: Palmerston North*

APPENDIX B

RESEARCH INTO WOMEN'S EXPERIENCE OF MENOPAUSE

INFORMATION SHEET

My name is Teresa Gracez. I am a graduate student in nursing at Massey University, School of Health Sciences, Albany Campus. I am interested in finding out women's experience of the menopause, in particular how women managed menopause 20 to 30 years ago. My supervisor is Dr. Jenny Carryer. She may be reached at Massey University, School of Health Sciences, Palmerston North, telephone 06- 356 5799, ext. 7719 or by phoning her mobile 025 491 302. Alternately, to avoid a toll call, you can ring Massey University: Albany, telephone 09-443-9700 and request to be redirected to Palmerston North.

What is the study about?

I am interested in capturing the experience of menopause, "the change" from a time when it was less talked about and less likely to be the subject of medical interest. For this reason, I am selecting potential participants who experienced menopause between 20 and 30 years ago. I will be asking questions such as, " How did women learn about menopause? How did they know they were in menopause? Who did they talk to? What role, if any did their doctor play? What information did they receive? What were their experiences?"

What would I have to do?

If you agree to participate, I will ask to meet with you once, to share with me your experience of menopause. This meeting can take place at your home or any other convenient location. You may have the interview alone or you may bring a friend who has agreed to participate if you wish. The interview should take approximately one hour, perhaps more if you choose to be interviewed with another participant present. I will ask your permission to audiotape the interview and I will be taking notes at the same time. I will ask you to sign a consent form as an agreement to participate in this study.

What are the benefits involved in my taking part?

The information you provide will contribute to our understanding of menopause as it was experienced in previous generations. It will give you the opportunity to share your experiences with other women. At the end of the study you will receive a summary of the results and so learn of other women's experience of menopause.

What are the risks involved in my taking part?

None.

What will the information I provide be used for?

The information you provide will be used for my research project and any publications, which arise from this work. In order to preserve your anonymity you will be invited to select a pseudonym (different name) by which you will be identified. The original notes and audiotapes will only be available to my supervisor, a typist who will transcribe the interview, and me. The transcriber will be asked to sign a Confidentiality Agreement.

What are my rights if I choose to take part?

Your participation is entirely voluntary. You do not have to take part in this study and this will in no way affect your future health care.

Should you agree to participate in this study, you have the right:

- To refuse to answer any particular questions
- To withdraw from this study at any time
- To ask for the audio-tape to be turned off at any time during the session
- To ask any questions about the study at any time during participation
- To provide information on the understanding your name will not be used unless you give permission
- To be given the results of this study if you so wish.

This study has received ethical approval from Massey University Human Ethics Committee: Palmerston North.

APPENDIX C

RESEARCH INTO WOMEN'S EXPERIENCE OF MENOPAUSE

CONSENT FORM

1. I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.
2. I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.
3. I agree to provide information to the researcher, her supervisor and the transcriber of audiotapes on the understanding that my name will not be used without my permission. The information will be used only for this research and any publication arising from this research study.
4. I understand that my consent form will be lodged with the researcher in a locked filing cabinet and all steps will be taken to ensure that participant anonymity is protected.
5. I agree / do not agree to the interview being audio taped.
6. I understand that I have the right to ask for the audiotape to be turned off at any time during the session.
7. I agree to participate in this study under the conditions set out in the Information Sheet.

Signed _____ Date _____
(participant)

APPENDIX D

RESEARCH INTO WOMEN'S EXPERIENCE OF MENOPAUSE LIST OF PROMPT QUESTIONS

1. Could you begin by telling me a little bit about why you responded my advertisement?
2. What does the term menopause mean to you?
3. How old were you when you were told or believed you were in menopause? How did you know you were in menopause?
4. Did you know anything about menopause?
5. Did you receive any advice about menopause? If yes, from whom did you receive this advice?
6. Did you anticipate that menopause would mean making changes in your life?
7. Did your relationship with your husband or others change?
8. Did you ever believe you had options regarding the management of menopause?
9. Please describe the time you knew you were in menopause.
10. Describe the process or the role if any in which your doctor took part in the management of your menopause.

APPENDIX E

RESEARCH INTO WOMEN'S EXPERIENCE OF MENOPAUSE CONFIDENTIALITY AGREEMENT

It is acknowledged that I will have access to confidential information regarding research participants.

I will not disclose any information I access through transcribing interview tapes or any word processing related to the above thesis research. I will take all reasonable steps to ensure the confidentiality of material while it is in my hands.

I understand to treat information obtained as completely confidential and will not divulge any information concerning participants to anyone, either directly or through casual conversation.

Signed _____ Date _____
(*Transcriber*)

REFERENCES

- Ahlborg, H.G., Johnell, O., Turner, C.H., Rannevit, G., & Karlsson, M.K. (2003). Bone loss and bone size after menopause. New England Journal of Medicine, 349 (4), 327 – 334.
- Anderson, M. (1998). Universal change – individual responses: Women’s experiences of the menopause and of taking hormone replacement therapy. Unpublished master’s thesis, Massey University, Palmerston North, New Zealand.
- Asso, D. (1983). The real menstrual cycle. Chichester: John Wiley & Sons.
- Ballinger, C.B. (1990). Psychiatric aspects of the menopause. British Journal of Psychiatry, 156, 773 – 787.
- Barile, L.A. (1997). Theories of menopause: Brief comparative synopsis. Journal of Psychosocial Nursing, 35 (2), 36 – 39.
- Beasley, A.N. (1999). Menopause in context: A constructivist / interpretative perspective on the attitudes, perceptions, expectations and experiences among women in New Zealand. Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand.
- Belenky, M.F., Clinchy, B.M., Goldberger, N.R., & Tarule, J.M. (1997). Women’s ways of knowing: The development of self, voice, and mind. New York: Basic Books
- Bell, S.E. (1987). Changing ideas: The medicalization of menopause. Social Science and Medicine, 24 (6), 535 – 542.
- Bell, S.E. (1990). Sociological perspectives on the medicalization of menopause. Annals of the New York Academy of Science, 592, 173 – 178.

Berger, G., & Forster, E. (2001). An Australian study on the sociocultural context of menopause: Directions for contemporary nursing practice. Contemporary Nurse, 11 (2-3), 271 – 282.

Blackwell, J.T., & Blackwell, D.A. (1997). Menopause: Life event or medical disease? Clinical Nurse Specialist, 11 (1), 7 – 9.

Boston women's health book collective: Our bodies, ourselves. (1976). New York: Simon & Schuster.

Brink, P., & Wood, M. (1988). Advanced design in nursing research. New Delhi: Sage.

Broom, D. (1995). Masculine medicine, feminine illness: Gender and health. In G. Lupton, & J. Najman (Eds.), Sociology of health and illness (pp. 99 – 112). Australia: Macmillan Education.

Browne, C.V. (1998). Women, feminisim, and ageing. New York: Springer Publishing Company.

Browne, A., & Comer-Calder, N. (2002). Do men go through the change? Weekend Herald, April 13 – 14, G3.

Budge, R.C., Stephens, C., & Carryer, J. (2000). Decision making: New Zealand women speak about doctors and HRT. New Zealand Family Physician, 27 (6), 41 – 47.

Burke, S. (2001). Boning up on osteoporosis. Nursing 2001, 31 (10), 36 – 43.

Burns, N., & Grove, S.K. (2001). The practice of nursing research: Conduct, critique, and utilization (4th ed). Philadelphia: W B Saunders Company.

Byles, J. (1998). A positive view of older women. Australia and New Zealand Journal of Public Health, 22 (7), 743 – 744.

Carlson, E.S., Li, S., & Holm, K. (1997). An analysis of menopause in the popular press. Health Care for Women International, 18, 557 – 564.

Carruthers, M. (2001). The testosterone revolution: Rediscover your energy and overcome the symptoms of male menopause. London: Thorsons Publishing.

Carroll, L. (1994). Alice's adventures in wonderland. London: Puffin Books. (Original published 1865)

Carryer, J. (1995). Feminist research: Strengths and challenges. Contemporary Nurse, 4 (4), 180 – 186.

Carryer, J. (1997). A feminist appraisal of the experience of embodied largeness: A challenge for nursing. Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand.

Chlebowski, R.T., Hendrix, S.L., Langer, R.D., Stefanik, M.L., Gass, M., Lane, D., Rodabough, R.J., Gilligan, M., Cyr, M.G., Thomson, C.A., Khandekar, J., Petrovitch, H., & McTeernan, A. (2003). Influences of estrogen plus progestin on breast cancer and mammography in healthy postmenopausal women: The Women's Health Initiative randomized trial. Journal of the American Medical Association, 289, 24, 3243 – 3253.

Clinkingbeard, C., Minton, B.A., Davis, J., & McDermott, K. (1999). Women's knowledge about menopause, hormone replacement therapy (HRT), and interactions with healthcare providers: An exploratory study. Journal of Women's Health Gender Based Medicine, 8 (8), 1097 – 1102.

Colville, W. (2002) Defying nature. Next, October, 68 – 77.

Coney, S. (1994). The menopause industry: How the medical establishment exploits women. Alameda, CA: Hunter house Inc.

Conrad, P. (1992). Medicalization and social control. Annual Review in Sociology, 18, 209 – 232.

Cousins, S.O., & Edwards, K. (2002). Alice in menopauseland: The jabberwocky of a medicalized middle age. Health Care for Women International, 23 (4), 325 – 343.

Crowley, H., & Himmelweit, S. (1992). Knowing women: Feminism and knowledge. Cambridge: The Open University.

Cutson, T.M., & Meuleuman, E. (2000). Managing menopause. American Family Physician, 61, 1391 – 1406.

Darke, G. (1996). Discourses on the menopause and female sexual identity. In J. Holland, & L. Adkin (Eds.), Sex, sexuality and the gendered body (pp. 136 – 158). UK: Basingstoke Macmillan.

Davis, D.L. (1992). The meaning of menopause in a Newfoundland fishing village. In J.M. Morse (Ed.), Qualitative health research (pp. 145 – 169). America: Sage Publications.

deBeauvoir, S. (1989). The second sex. (H.M. Parshley, Trans.). New York: Vintage books. (Original work published 1953)

DeBoni, D. (2002). HRT under review by drug agency. New Zealand Herald, September 23, A2.

Defey, D., Storch, E., Cardozo, S., Diaz, O., & Fernandez, G. (1996). The menopause: Women's psychology and health care. Social Science and Medicine, 42 (10), 1447 – 1456.

DeMarco, R., Campbell, J., & Wuest, J. (1993). Feminist critique: Searching for meaning in research. Advances in Nursing Science, 16 (2), 26 – 38.

DeSouza, M. (1994). The colours of menopause. In N. Worcester, & M.H. Whatley (Eds.), Women's health: Readings on social, economic, and political issues (2nd ed.) (pp. 216 – 218). Dubuque, IO: Kendall / Hunt Publishing Company.

Dickson, G.L. (1990). A feminist poststructuralist analysis of the knowledge of menopause. Advances in Nursing Science, 12 (3), 15 – 31.

Dietsch, E. (1995). Is it pathological to be female? Oestrogen deficiency symptoms in 847 women aged 15 to 69 years. The Australian Journal of Advanced Nursing, 12 (2), 8 – 13.

Ehrenreich, B., & English, D. (1979). For her own good: 150 years of experts advice to women. New York: Anchor Press / Doubleday.

Fauconnier, A., Ringa, V., Delanoe, D., Falissard, B., & Breart, G. (2000). Use of hormone replacement therapy: Women's representations of menopause and beauty care practices. Maturitas, 35 (3), 215 – 228.

Field, P.A., & Morse, J.M. (1995). Qualitative research methods for health professionals (2nd ed). Thousand Oaks, CA: Sage Publications.

Fisher, S. (1986). In the patient's best interest: Women and the politics of medical decisions. New Jersey: Rutgers University Press.

Fiske, S.T. (1993). Controlling other people: The impact of power on stereotyping. American Psychologist, 48 (6), 621 – 628.

Fodor, I.G., & Franks, V. (1990). Women in midlife and beyond: The new prime of life? Psychology of Women Quarterly, 14, 445 – 449.

Formanek, R. (1988). Menopause: Myth and reality. In J. Offerman-Zuckerberg (Ed.), Critical psychophysical passages in the life of a woman: A psychodynamic perspective (pp. 199 – 214). New York: Plenum Publishing Corporation.

Forster, M. (1994). How was it for you? In J. Goldworthy (Ed.), A certain age: Reflecting on menopause (pp. 147 – 158). New York: Columbia University Press.

Friedan, B. (1993). The fountain of age. London: Vintage.

Gannon, L. (1998). The impact of medical and sexual politics on women's health. Feminism and psychology, 8 (3), 285 – 302.

Gannon, L., & Ekstrom, B. (1993). Attitudes towards menopause: The influence of sociocultural paradigms. Psychology of Women Quarterly, 17, 275 – 288.

George, S.A. (2002). The menopause experience: A women's perspective. Journal of Obstetrical, Gynecological and Neonatal Nursing, 31, 77 – 85.

Gerrard, D. (2000). Women still fighting fit postmenopause. New Zealand Doctor, March, 29.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Polity Press.

Gonyea, J.G. (1996). Finished at fifty: The politics of the menopause and hormone replacement therapy. American Journal of Preventive Medicine, 12 (5), 415 – 419.

Gould, D.C., & Petty, R. (2000). The male menopause – does it exist? British Medical Journal, 320, 858 – 861.

Greenspan, S.L., Resnick, N.M., & Parker, R.A. (2003). Combination therapy with hormone replacement and alendronate for prevention of bone loss in elderly women: A

randomized control trial. Journal of the American Medical Association, 289, (19), 2525 – 2533.

Greer, G. (1991). The change: Women, ageing and the menopause. New York: Fawcett Columbine.

Greer, G. (1999). The whole woman. Great Britain: Doubleday.

Griffiths, F. (1999). Women's control and choice regarding HRT. Social Science and Medicine, 49, 469 – 481.

Gullette, M.M. (1997). Menopause as a magic marker. In P. Komesaroff, P. Rothfield, & J. Daly (Eds.), Reinterpreting menopause: Cultural and philosophical issues (pp. 176 – 199). New York: Routledge.

Hall, J.M., & Stevens, P.E. (1991). Rigor in feminist research. Advances in Nursing Science, 13 (3), 16 – 29.

Harding, T. (1996). In the company of other women: A case study of menopause support groups. In J. Pilcher, & A. Coffey (Eds.), Gender and qualitative research (pp. 98 - 113). Aldershot, UK: Ashgate Publishing Ltd.

Hays, J., Ockene, J.K., Brunner, R.L., Kotcher, J.M., Manson, J.E., Patterson, R.E., Aragaki, A.K., Shumaker, S.A., Brzyski, R.G., LaCroix, A.Z., Granek, I.A., & Valanis, B.G. (2003). Effects of estrogen plus progestin on health-related quality of life. New England Journal of Medicine, 348, (19), 1839 – 1854.

Hill, A. (2002). Experts take heat out of HRT furore. New Zealand Herald, July 15, A8.

Hulley, S., Grady, D., Bush, T., Furberg, C., Herrington, D., Riggs, B., & Vittinghoff, E. (1998). Randomized trial of estrogen plus progestin for secondary prevention of coronary

heart disease in postmenopausal women. Journal of the American Medical Association, 280 (7), 605 – 613.

Hunt, K. (1994). A 'cure for all ills'? Constructions of the menopause and the chequered fortune of hormone replacement therapy. In S. Wilkinson, & C. Kitzinger (Eds.), Women and health (pp. 141 – 165). London: Taylor & Francis Ltd.

Hunter, M.S., O'Dea, I., & Britten, N. (1997). Decision-making and hormone replacement therapy: A qualitative analysis. Social Science and Medicine, 45 (19), 1541 – 1548.

Huntington, A. (1996). Nursing research reframed by the inescapable reality of practice: A personal encounter. Nursing Inquiry, 3, 167 – 171.

Jackson, S. (1998). Feminist social theory. In S. Jackson, & J. Jones (Eds.), Contemporary feminist theories (pp. 12 – 32). Edinburgh: Edinburgh University Press.

Jones, J. (1994). Embodied meanings: Menopause and the change of life. Social Work in Health Care, 19 (314), 43 – 65.

Jordanova, L. (1989). Sexual visions: Images of gender in science and medicine between the eighteenth and twentieth centuries. Great Britain: Harvester Wheatsheat.

Kaufert, P.A., & Gilbert, P. (1986). Women, menopause, and medicalization. Culture, Medicine and Psychiatry, 10, 7 – 21.

Kaufert, P.A. (1982). Myth and the menopause. Sociology of Health and Illness, 4 (2), 141 – 166.

Kaufert, P.A., & Lock, M. (1997). Medicalization of women's third age. Journal of Psychosomatic Obstetrics and Gynecology, 18, 81 – 86.

Kearns, B. (2002). Taming your raging hormones. Good Housekeeping, July, 85 – 88.

King, K.E. (1994). Method and methodology in feminist research: What is the difference? Journal of Advanced Nursing, 20, 19 – 22.

Kittell, L.A., Mansfield, P.K., & Voda, A.M. (1998). Keeping up appearances: The basic social process of the menopause transition. Qualitative Health Research, 8 (5), 618 – 633.

Klein, R., & Dumble, L.J. (1994). Disempowering midlife women: The science and politics of hormone replacement therapy (HRT). Women's Studies International Forum, 17 (4), 327 – 343.

Lamb, G.S., & Huttlinger, K. (1989). Reflexivity in nursing research. Western Journal of Nursing Research, 11 (6), 765 – 772.

Lee, C. (1998). Women's health: Psychological and social perspectives. London: Sage Publications.

Lee, H.S., & Choi, K.S. (2002). Experiences of postmenopausal women of hormone replacement therapy. Nursing and Health Sciences, 4 (3), A10.

Lemaire, G.S., & Lenz, E.R. (1995). Perceived uncertainty about menopause in women attending an educational program. International Journal of Nursing Studies, 32 (1), 39 – 48.

Lewin, K.J., Sinclair, H.K., & bond, C.M. (2003). Women's knowledge of and attitudes towards hormone replacement therapy. Family Practice, 20 (2), 112 – 119.

Lewis, J. (1993). Feminism, the menopause and hormone replacement therapy. Feminist Review, 43, 38 – 56.

Li, C.I., Malone, K.E., Porter, P.L., Weiss, N.S., Tang, M.C., Cushing-Haugen, K.L., & Daling, J.R. (2003). Relationship between long durations and different regimens of

hormone therapy and risk of breast cancer. Journal of the American Medical Association, 289, (24), 3254 – 3263.

Lindsey, L.L. (1997). Gender roles: A sociological perspective (3rd ed.). New Jersey: Prentice Hall.

Lippman, A. (1998). The politics of health: Geneticization versus health promotion. In S. Sherwin (Coordinator), The politics of women's health: Exploring ageing and autonomy (pp. 64 – 82). Philadelphia: Temple University Press.

Lock, M. (1982). Models and practice in medicine: Menopause as a syndrome or life transition? Culture, Medicine and Psychiatry, 6, 261 – 280.

Lock, M. (1998). Anomalous women and political strategies for aging societies. In S. Sherwin (Ed.), The politics of women's health: Exploring agency and autonomy (pp. 178 – 204). Philadelphia: Temple University Press.

Lock, M., & Kaufert, P. (2001). Menopause, local biologies, and cultures of aging. American Journal of Human Biology, 13, 494 – 504.

Loppie, C., & Keddy, B. (2002). A feminist analysis of the menopause discourse. Contemporary Nurse, 12 (1), 92 – 99.

Lupton, D. (1994). Medicine as culture: Illness, disease and the body in western societies. London: Sage Publications Ltd.

MacPherson, K.I. (1981). Menopause as a disease: The social construction of a metaphor. Advances in Nursing Science, 3 (2), 95 – 113.

Manson, J.E., Hsia, J., Johnson, K.C., Roussouw, J.E., Assaf, A.R., Lasser, N.L., Trevisan, M., Black, H.R., Heckbert, S.R., Detrano, R., Strickland, O.L., Wong, N.D.,

Crouse, J.R., Stein, E., & Cushman, M. (2003). Estrogen plus progestin and the risk of coronary heart disease. New England Journal of Medicine, 349 (6), 523 – 534.

Matthews, K.A. (1992). Myths and realities of menopause. Psychosomatic Medicine, 54, 1 – 9.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. British Medical Journal, 311, 109 – 112.

McDowell, L., & Pringle, R. (1992). Defining women: Social institutions and gender divisions. Cambridge: The Open University Press.

Meleis, A.I. (1997) Theoretical nursing: Development and progress (3rd ed.). Philadelphia: Lippincott.

Mies, M. (1983). Towards a methodology for feminist research. In G. Bowles, & R.D. Klein (Eds.), Theories for women's studies (pp. 117 – 139). London: Routledge & Kegan Paul.

Moen, P., Dempster-McClain, D., & Williams Jr., R.M. (1992). Successful aging: A life course perspective on women's multiple roles and health. American Journal of Sociology, 97 (6), 1612 – 1638.

Morelli, V., & Naquin, C. (2002). Alternative therapies for traditional disease states: Menopause. American Family Physician, 66, 129 – 134.

Morgan, K.P. (1998). Contested bodies, contested knowledge: Women, health and the politics of medicalization. In S. Sherwin (Ed.), The politics of women's health: Exploring agency and autonomy (pp. 83 - 121). Philadelphia: Temple Press University.

National Advisory Committee on Core Health and Disability Support. (1993). Hormone replacement therapy. Wellington, New Zealand.

Nash, D., Magder, L., Lustberg, M., Sherwin, R.W., Rubin, R.J., Kaufmann, R.B., & Silbergeld, E.K. (2003). Blood lead, blood pressure, and hypertension in perimenopausal and postmenopausal women. Journal of the American Medical Association, 289, (12), 1523 – 1532.

New Zealand Guidelines Group (2001). The appropriate prescribing of hormone replacement therapy. Wellington, New Zealand.

North, F., & Sharples, K. (2001). Changes in the use of hormone replacement therapy in New Zealand from 1991 – 1997. New Zealand Medical Journal, 114, 250 – 253.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), Doing feminist research (pp. 30 – 61). London: Routledge & Kegan Paul.

Oakley, A. (1993). Essays on women, medicine and health. Edinburgh: Edinburgh University Press.

Oddens, B.J., Boulet, M.J., Lehert, P., & Visser, A.P. (1992). Has the climateric been medicalized? A study on the use of medication for climateric complaints in four countries. Maturitas, 15, 171 – 181.

Ogilvie, R.A. (2001). Is it perimenopause? Health & Beauty, February / March, 72 – 74.

Parker, B., & McFarlane, J. (1991). Feminist theory and nursing: An empowerment model for research. Advances in Nursing Science, 13 (3), 59 – 67.

Phillips, A., & Rakusen, J. (Eds.). (1996). Boston Women's Health Collective: The new our bodies, ourselves. Auckland, New Zealand: Penguin Books.

Polit, D.F., & Hungler, B.P. (1997). Essentials of nursing research: Methods, appraisals, and utilization (4th ed). Philadelphia: Lippincott-Raven.

Posner, J. (1979). It's all in your head: Feminist and medical models of menopause (strange bedfellows). Sex Roles, 5 (2), 179 – 190.

Pringle, R. (1998). Sex and medicine: Gender, power and authority in the medical profession. Cambridge: Cambridge University Press.

Quinn, A.A. (1991). A theoretical model of the perimenopausal process. Journal of Nurse-Midwifery, 36 (1), 25 – 29.

Reinharz, S. (1992). Feminist methods and social research. New York: The Oxford University Press.

Riessman, C.K. (1989). Women and medicalization: A new perspective. In P. Brown (Ed.), Perspectives in medical sociology (pp. 190 – 220). Prospect Heights, IL: Waveland Press Inc.

Roberts, J., Chambers, L.F., Blake, J., & Webber, C. (1992). Psychosocial adjustments in post-menopausal women. The Canadian Journal of Nursing Research, 24 (4), 29 – 46.

Robertson, M.E. (1995). Change of life. In L. Taetzsch (Ed.), Hot flashes: Women writers on the change of life (pp. 102 – 109). Boston: Faber & Faber.

Rymer, J., Wilson, R., & Ballard, K. (2003). Making decisions about hormone replacement therapy. British Medical Journal, 326, 322 – 326.

Sandelowski, M. (2000). Whatever happened to qualitative description? Research in Nursing and Health, 23, 334 – 340.

Seaman, C.H.C. (1987). Research methods: Principles, practice, and theory for nursing (3rd ed.). Norwalk, CT: Appleton & Lange.

Seattle Midlife Women's Health Study. (2002). University of Washington, Seattle, [Online]. Available: <http://www.son.washington.edu/departments/fcn/smwhs>.

Seibold, C., Richards, L., & Simon, D. (1994). Feminist methods and qualitative research about midlife. Journal of Advanced Nursing, 19, 394 – 402.

Sheehy, G. (1998). Menopause: The silent passage. New York: Simon & Schuster Inc.

Shumaker, S.A., Legault, C., Rapp, S.R., Leon, T., Wallace, R.B., Ockene, J.K., Hendrix, S.L., Jones, B.N., Assaf, A.R., Jackson, R.D., Kotcher, J.M., Wassertheil-Smoller, S., & Wactawski-Wende, J. (2003). Estrogen plus progestin and the incidence of dementia and mild cognitive impairment in postmenopausal women. Journal of the American Medical Association, 289 (20), 2651 – 2662.

Siegal, D.L., & Doress-Worters, P.B. (1994). The new ourselves, growing older: Women aging with knowledge and power. New York: Simon & Schuster.

Sievert, L.L. (2001). Menopause as a measure of population health: An overview. American Journal of Human Biology, 13, 429 – 433.

Sigsworth, J. (1995). Feminist research: Its relevance to nursing. Journal of Advanced Nursing, 22, 896 – 899.

Smith, D.E. (1998). The everyday world as problematic: A feminist sociology. Toronto: University of Toronto Press.

Smith-Rosenberg, C. (1985). Disorderly conduct: Visions of gender in Victorian America. New York: Oxford University Press.

Spitzer, D. (1995). More than the Change: Diversity and flexibility in menopausal experience. In L. Taetzsch (Ed.), Hot flashes: Women writers on the change of life (pp. 115 – 128). Boston: Faber & Faber.

Stanley, L. (1990). Feminist praxis: Research, theory and epistemology in feminist sociology. London: Routledge.

Stanley, L., & Wise, S. (1990), Method, methodology and epistemology in feminist research processes. In L. Stanley (Ed.), Feminist praxis: Research, theory and epistemology in feminist sociology (pp. 20 – 59). London: Routledge.

Statistics New Zealand, (2000). New Zealand official yearbook, Te Pukapuka Houanga Whaimara o Aotearoa (102 ed). Wellington.

Stephens, C. (2001). Women's experience at the time of menopause: Accounting for biological, culture and psychological embodiment. Journal of Health Psychology, 6 (6), 651 – 663.

Stephens, C., Carryer, J., & Budge, R.C. (2001). Decisions about starting and ceasing HRT use: Information needs of women. Nursing Praxis in New Zealand, 17 (2), 33 – 43.

Stephens, C., & Ross, N. (2002). The relationship between hormone replacement therapy use and psychological symptoms: No effects found in a New Zealand sample. Health Care for Women International, 23 (4), 408 – 414.

Sybylla R. (1997). Situating menopause within the strategies of power: A genealogy. In P.A. Komesaroff, P. Rothfield, & J. Daly (Eds.), Reinterpreting menopause: Cultural and philosophical issues (pp. 200 – 221). New York: Routledge.

Taylor, S.J., & Bogdan, R. (1998). Introduction to qualitative research methods: A guidebook and resource (3rd ed.). Toronto: John Wiley & Sons Inc.

Thomas, S. (1997). Distressing aspects of women's roles, vicarious stress, and health consequences. Issues in Mental Health Nursing, 18, 539 – 557.

Thompson, D. (1994). Defining feminism. Australian feminist studies, 20, 171 – 192.

Tolich, M., & Davidson, C. (1999). Starting fieldwork: An introduction to qualitative research in New Zealand. Auckland, New Zealand: Oxford University Press.

- Tong, R.P. (1998). Feminist thought (2nd ed). St. Leonards, Australia. Allen & Unwin.
- Tuana, N. (1988). The weaker seed: The sexist bias of reproductive theory. Hypatia, 3 (1), 147 – 171.
- Turia, D.P. (1998). Menopause: Women's knowledge sources and management decisions. Unpublished master's thesis, Massey University, Palmerston North, New Zealand.
- Utian, W.H. (1980). Your middle years: A doctor's guide for today's woman. New York: Appleton-Century-Crofts.
- Warga, C.L. (1999). Menopause and the mind: The complete guide to coping with the cognitive effects of perimenopause and menopause, including memory loss, foggy thinking, and verbal slips. New York: Simon & Schuster.
- Webb, C. (1992). Feminist research: Definitions, methodology, methods and evaluation. Journal of Advanced Nursing, 18, 416 – 423.
- White, C. (2002). Second long term trial stopped early. British Medical Journal, 325, 987.
- Whittaker, R. (1998). Re-framing the representation of women in advertisements for hormone replacement therapy. Nursing Inquiry, 5, 77 – 86.
- Wilson, R. (1966). Feminine forever. New York: M. Evans.
- Women's Health Watch. (2001). HRT – the good, the bad, and the flakey [On-line] Available: <http://www.womens-health.org.nz/whwjun01.htm>.
- World Health Organization (WHO). (1996). Research on the menopause in the 1990s. Geneva.

Worcester, N., & Whatley, M.H. (1992). The selling of HRT: Playing on the fear factor. Feminist Review, 41, 1 – 26.

Wright, J. (1998). Older women's experience of the menopause. Nursing Standard, 12 (47), 46 – 48.